MASSAGE THERAPY

Name____ **Date of Birth**_____________ **Age**___________

Address______________________________________**City**________________**State**_____**Zip**_________

Home Phone______________________________**Cell Phone**____________________________________

Email Address____ **Gender: M F**

How did you hear about us?______________________________**Occupation**_______________________

Emergency Contact Name____________________________________**Phone**_______________________

Please indicate if you have any of the following conditions; certain medications and health problem may be contraindicated for massage. If necessary, a physicians release may be required from your primary care provider.

	Yes	No	Additional Information
Arthritis			
Diabetes			**Type I or Type II**________________________
Frequent Headaches			**How Often**____________________________
High Blood Pressure			
Epilepsy or Seizures			
Joint Swelling			**Where**_______________________________
Varicose Veins			**Where**_______________________________
Contagious Disease			**Explain**______________________________
Osteoporosis			
Allergies			**To What**_____________________________
Back Pain			
Knee Pain			
Other Joint Pain			**Where**_______________________________
Surgery			**For What**_____________________________
Frequent Numbness or Tingling			**Where**_______________________________
Pregnant			**How far along**___________________________
Recent Injury			**Explain**______________________________
Allergy to Lotion or Oils			**What Type**____________________________

Please list any medications you are currently taking____

Please list any other medical conditions you may suffer from not listed above____________________________________

____

Please Initial Below:

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session I will immediately inform the practitioner so that the pressure and or strokes may be adjusted to my level of comfort. _____

I understand that massage or bodywork should not be considered a substitute for medical care. _____

I agree to keep the practitioner updated on any changes in my medical profile and understand that there should be no liability on the practitioners' part if I fail to do so. _____

I understand that if I fail to give 24 hours notice of cancellation for my massage appointment I will be billed a fee of $25.00. _____

I understand that any illicit or sexually aggressive remarks or advances made will result in immediate termination of the session and I will still be liable for payment of the scheduled appointment. _____

I affirm that I have stated all my known medical conditions and have answered all questions honestly.

Client Signature____**Date**_________________

Signature of Parent or Guardian (if under 18)____**Date**_________________