Confidential Client Information and Health History

First Name: ________________________MI: ______Last Name (Please Print): ______________________________________

Telephone: (Home or Cell) _______________________________ Email: ____

Emergency Contact: ____ Phone: _______________________________

How did you hear about us? ____

Is this your very first massage? ☐ Yes or ☐ No

If no, when was the last time you had a massage? ____

Please **check** ✓ any of the following conditions you have currently.

- ☐ Neck/Spine Injury
- ☐ Back Pain
- ☐ Sciatica/Leg Pain
- ☐ Carpal Tunnel Syndrome
- ☐ TMJ Syndrome
- ☐ Sports Injuries
- ☐ Headaches
- ☐ Broken Bones
- ☐ Numbness/Stabbing Pains
- ☐ Sensitive Touch/Pressure
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Restrictions in Movement
- ☐ Circulatory Problems
- ☐ Anxiety/Stress/ Trouble Relaxing
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Skin Disorders
- ☐ Infectious Diseases
- ☐ Arthritis
- ☐ Cold/Flu/Fever
- ☐ Varicose Veins
- ☐ Contact Lenses
- ☐ Epilepsy/Seizures
- ☐ Joint Swelling
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Allergies
- ☐ Liver Ailment
- ☐ Kidney Ailment
- ☐ Heart Ailment
- ☐ Fibromyalgia
- ☐ PMS Syndrome
- ☐ Grief Process

Other ______________
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____

Please state any injuries, surgeries, accidents or medical treatments which would interfere with your session(i.e. frozen shoulder etc.): ____

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Are there any parts of your body you would like the therapist to concentrate on or do you have any other special requests for today's session (i.e. minimal chatting, avoid feet, no scents etc.)? _______________________________________

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What physical activities do you regularly participate in? ____

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The above information is accurate and true to the best of my knowledge. I understand that the therapists do not diagnose disease, prescribe medication or manipulate bones. I further understand that massage therapy is not suitable for medical attention or examination. Because massage therapy should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health and understand that there shall be no liability on the practitioners part should I forget to do so. It is also understood that any illicit or sexual suggestive remarks or advances made by me will result in immediate termination of the session, and will be liable for full payment of scheduled appointment. I understand that it is my responsibility to stop the session if I do not like the session - full sessions will be charged accordingly - stopped sessions will also be discounted accordingly. I also understand that canceled or missed appointments without 3 or 4 hour notice (emergencies excluded) may be charged for the missed session.

Signature: ____ Date: __________________