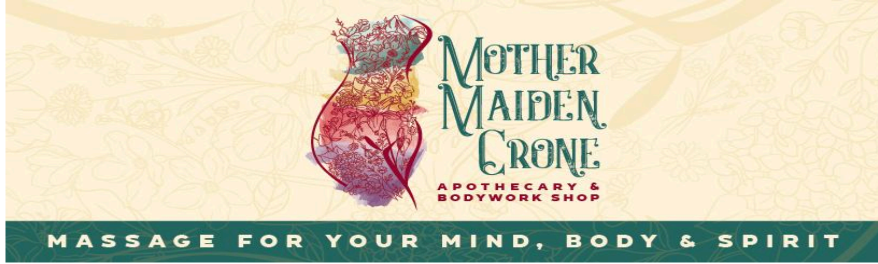


Client Contact Information

First Name: ________________________________ Last Name:______________________________

Phone Number:______________________ Email:_________________________________

Birth date:____________________

Street address:____

City:______________________________State:________________Zip code:__________________

Emergency Contact Information

Contact Name:_________________________________ Relationship:__________________________

Phone Number:___________________

Doctor Contact Information (Required for Pregnant Clients and Medical Massage Patients)

Doctor's Name:___________________________Phone Number:___________________________

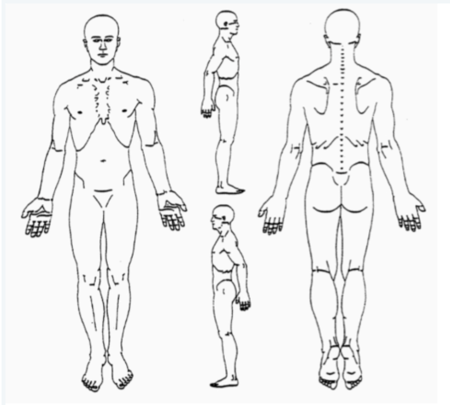
How did you hear about us?____

Issues to Address

How do you feel in your body today?
Mark on the scale
Fabulous *---* Horrible

I give you space to explain:

Mark the areas in question and describe sensation(s) i.e. tight, sharp pain, sore, bruising, dull ache, etc.



Have you had any recent injuries, surgeries, or illnesses? Yes or No
If YES, please explain:____

____

Cause of injury or concern:____
Treatment Goals:____
Focus Requests: 1)_______________________ 2)_______________________ 3)_______________________
Have you received a massage before? Yes or No

Medical History

RESPIRATORY

- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Chronic Cough
- ☐ Emphysema

CARDIOVASCULAR

- ☐ Blood Clots
- ☐ Cold Hands
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Varicose Veins
- ☐ Cardiovascular Accident
- ☐ Congestive Heart Failure
- ☐ Low Blood Pressure
- ☐ Phlebitis
- ☐ Cerebral-vascular Accident
- ☐ Heart Attack
- ☐ Stroke
- ☐ Lymphedema
- ☐ Cold Feet
- ☐ Heart Disease
- ☐ Thrombosis/Embolism
- ☐ Myocardial Infarction

SKIN

- ☐ Bruise Easily
- ☐ Skin Irritations
- ☐ Hypersensitive Reaction
- ☐ Melanoma
- ☐ Skin Conditions

HEAD & NECK

- ☐ Ear Problems
- ☐ Hearing Loss
- ☐ Sinus Problems
- ☐ Vision Problems
- ☐ Vision Loss
- ☐ Migraines

- [ ] Headaches
- [ ] Jaw Pain (TMJD)

INFECTIOUS CONDITIONS

- [ ] Athlete's Foot
- [ ] Respiratory Conditions
- [ ] Hepatitis
- [ ] Skin Conditions
- [ ] HIV
- [ ] Herpes

REPRODUCTIVE

- [ ] Pregnancy
- [ ] Recent Abortion, Miscarriage, or StillBirth
- [ ] Gynecological Issues

FAMILY HISTORY

- [ ] Cardiovascular Conditions
- [ ] Respiratory Conditions

NEUROLOGICAL

- [ ] Burning
- [ ] Numbness
- [ ] Tingling
- [ ] Stabbing Pain
- [ ] Cerebral Palsy
- [ ] Parkinsons
- [ ] Multiple Sclerosis
- [ ] Herniated Disc

MISCELLANEOUS

- [ ] Allergies
- [ ] Cancer
- [ ] Dizziness
- [ ] Hemophilia
- [ ] Mental Illness
- [ ] Surgical Pins or Wire
- [ ] Anaphylaxis
- [ ] Crohn's Disease
- [ ] Epilepsy
- [ ] Arthritis
- [ ] Osteoarthritis
- [ ] Rheumatoid Arthritis

- ☐ Artificial Joints/Special Equipment
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Loss of Sensation
- ☐ Osteoporosis
- ☐ Shingles
- ☐ Stress
- ☐ Digestive Conditions
- ☐ Insomnia
- ☐ Gout
- ☐ Lupus
- ☐ Other Diagnosed Diseases
- ☐ Other Medical Conditions
- ☐ Allergies and other conditions your provider should be aware of:____
  __

MEDICATIONS

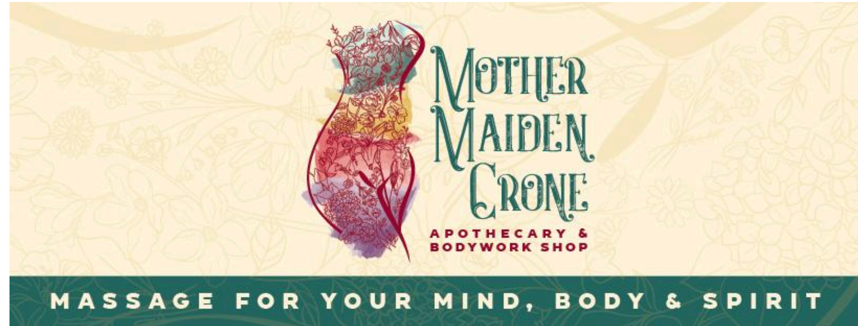
Please list any medications or drugs you are currently on:

____

____

____

____



Client Waiver Form

Please take a moment to read and initial the following information:

- I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.
- If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.
- I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.
- I affirm that I have notified my therapist of all known medical conditions and injuries.
- I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.
- I understand that massage is entirely therapeutic and non-sexual in nature.
- By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.

I have read the statement above and agree to all the policies

Signature:____Date:______________
Print Client Name:_______________________________________

If signing as a guardian PRINT SIGNATURE
NAME:____
Relationship to Client:_____________________________