MASSAGE CLIENT WELCOME FORM

Name____Date_______________________________

DOB________________ M____________F____

Address_________________________________City_____________State________Zip________

Email____

Home Phone___________________Work Phone______________Cell Phone_____________

Occupation____

Where did you hear of us?____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care physician may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? ___Y _____N

How recently?____

Your reason for obtaining treatment: __________Relaxation____________________Pain/Injury

Other____

What kind of pressure do you prefer? _________light_________medium____________firm

If you answer "yes" to any of the following questions, please explain as clearly as possible.

____ Yes ____ No Do you frequently suffer from stress?
____ Yes ____ No Do you have diabetes?
____ Yes ____ No Do you experience frequent headaches?
____ Yes ____ No Are you pregnant?
____ Yes ____ No Do you suffer from arthritis?
____ Yes ____ No Are you wearing contact lenses?
____ Yes ____ No Are you wearing dentures?
____ Yes ____ No Do you have high blood pressure?
____ Yes ____ No Are you taking high blood pressure medication?
____ Yes ____ No Do you suffer from epilepsy or seizures?
____ Yes ____ No Do you suffer from joint swelling?
____ Yes ____ No Do you have varicose veins?
____ Yes ____ No Do you have any contagious diseases? _________________________
____ Yes ____ No Do you have osteoporosis?
____ Yes ____ No Do you have any allergies? ______________________________________
____ Yes ____ No Do you bruise easily?
____ Yes ____ No Any broken bones in the past two years? ___________________________

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____ Yes ____ No Any injuries in the past two years? ________________________________
____ Yes ____ No Do you have tension or soreness in a specific area? Please specify.

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____ Yes ____ No Do you have cardiac or circulatory problems?
____ Yes ____ No Do you suffer from back pain?
____ Yes ____ No Do you have numbness or stabbing pains?
____ Yes ____ No Are you sensitive to touch or pressure in any area?
____ Yes ____ No Have you ever had surgery? Explain below.
____ Yes ____ No Other medical condition, or are you taking any medications I should know about?

Comments ____

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I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should be not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature____Date_______________________

Practitioner Signature____________________________________Date_______________________

Consent to Treatment of Minor:
By my signature below, I hereby authorize ____
to administer massage or bodywork to my child or dependent as they deem necessary.

Signature of Parent or Guardian______________________________________Date_____________