



Name \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail: \_\_\_\_\_

Referred by: \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

In case of emergency: \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Occupation \_\_\_\_\_  Male  Female Physician \_\_\_\_\_

Health Insurance Carrier \_\_\_\_\_

**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 provider may be required prior to service being provided.**

Have you ever experienced a professional massage or bodywork session?  Yes  No How recently? \_\_\_\_\_

What are your massage or bodywork goals? \_\_\_\_\_

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 bruise easily?
- Yes  No Do you have diabetes?  Yes  No Any broken bones in the past two years?
- Yes  No Do you experience frequent headaches?  Yes  No Any injuries in the past two years?
- Yes  No Are you pregnant?  Yes  No Do you have tension or soreness in a specific area?  
Please specify \_\_\_\_\_
- 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 cardiac or circulatory problems?
- Yes  No Do you have high blood pressure?  Yes  No Do you suffer from back pain?
- Yes  No Are you taking high blood pressure medication?  Yes  No Do you have numbness or stabbing pains?
- Yes  No Do you suffer from epilepsy or seizures?  Yes  No Are you sensitive to touch or pressure in any area?
- Yes  No Do you suffer from joint swelling?  Yes  No Have you ever had surgery? Explain below.
- Yes  No Do you have varicose veins?  Yes  No Other medical condition, or are you taking any medications I should know about?
- Yes  No Do you have any contagious diseases? \_\_\_\_\_
- Yes  No Do you have osteoporosis? \_\_\_\_\_
- Yes  No Do you have any allergies? \_\_\_\_\_

Comments \_\_\_\_\_

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 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, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_