Massage Client Information

Name: _____Telephone ( ) _____

Date of Birth _____ Referred by: _____

Address _____ City _____State ___Zip _____

In Case of Emergency _____ ( ) _____

General and Medical Information

Occupation _____Age___ ☐ male ☐ female

Physician _____

☐ Yes ☐ No Have you ever experienced a professional massage session?

How recently? _____

(Please take a moment to carefully read the following information and sign where indicated. I you have a specific medical condition or specific symptoms, massage may be contraindicated.)

(If you answer 'Yes' to any of the following questions, please explain as clearly as possible.)

Are you pregnant? ☐ Yes ☐ No

Do you frequently suffer from stress? ☐ Yes ☐ No

Do you have diabetes? ☐ Yes ☐ No

Do you experience frequent headaches? ☐ Yes ☐ No

Do you suffer from arthritis? ☐ Yes ☐ No

Do you have high blood pressure? ☐ Yes ☐ No

If 'yes' to the previous question, are you taking medication? _____

Do you suffer from epilepsy or seizures? ☐ Yes ☐ No

Do you suffer from joint swelling? ☐ Yes ☐ No

Do you have any contagious diseases? ☐ Yes ☐ No

Do you have osteoporosis? ☐ Yes ☐ No

Do you suffer from allergies? ☐ Yes ☐ No

Do you bruise easily? ☐ Yes ☐ No

Do you suffer from back pain? ☐ Yes ☐ No

Please specify _____

Have you had any surgery? ☐ Yes ☐ No

Please specify: _____

Do you have numbness or stabbing pains anywhere?

☐ Yes ☐ No

Have you been in an accident or suffered any injuries in the past 2 years?

☐ Yes ☐ No

Do you have tension or soreness in a specific area?

☐ Yes ☐ No

*If yes, please specify*_____

Do you have any other medical condition or are you taking any medications that I should know about?

☐ Yes ☐ No

*If 'yes' please specify*_____

**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 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 aliment of which I am aware. 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.*

Client Signature _____ *Date* _____

Practitioner Signature _____*Date* _____

***Consent to Treatment of a Minor**: By my signature below, I hereby authorize* _____ *to administer massage to my child or dependent.*

Parent/ Guardian Signature _____ *Date* _____