Massage Client Information

Date:_____

Name: _____Phone No (_____)_____
Date of Birth _____ Cell (_____) _____
Address _____ State____Zip_____
Email: _____Referred by:_____
Emergency Contact _____ Phone No ( ) _____

General and Medical Information

Occupation _____ Age_____ ☐ Male ☐ Female
☐ Yes ☐ No Have you ever had a professional massage? How recently_____
Are you having any problems that would compromise your safety if you were to have a massage today? ☐ YES ☐ NO

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

(If you answer 'Yes' to any of the following questions, please explain as clearly as possible.)
Do you take daily medications? If so, please indicate_____
_____
Are you pregnant? ☐ Yes ☐ No
Do you have any contagious diseases? ☐ Yes ☐ No
Do you bruise easily? ☐ Yes ☐ No
Do you exercise regularly ☐ Yes ☐ No
Have you had any surgeries? ☐ Yes ☐ No
Please specify: _____
Have you had 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 OF THE FOLLOWING?

__ Allergies	__ Eating Disorders	__ Lupus
__ Arthritis	__ Epilepsy/Seizures	__ Numbness/Tingling
__ Athletes Foot	__ Fibromyalgia	__ Osteoporosis
__ Cancer/Tumors	__ HBP	__ Rash/Hives
__ Chronic Fatigue	__ Herpes	__ Shingles
__ Depression	__ HA's/Migranes	__ Shoulder/Arm Pain
__ Diabetes	__ IBS	__ Sleep Disorder
__ Drug/Alcohol Addiction	__ Jaw Pain / TMJ	__ Spasms/Cramps
	__ Leg/Hip Pain	__ Varicose Veins

**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 treatment 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 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 FOR TREATMENT OF A MINOR:

I hereby authorize below for _____ (Practioner) to

massage my minor child or dependent _____(name)

Parent/Legal Guardian Signature_____ Date_____