

## Confidential Client Information

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_

Phone: (Day #) \_\_\_\_\_ (Eve #) \_\_\_\_\_

When and where is the best time to reach you? \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email address: \_\_\_\_\_

In case of emergency please contact: \_\_\_\_\_

at (\_\_\_\_\_) \_\_\_\_\_ relation: \_\_\_\_\_

Referred By: \_\_\_\_\_

Would you like to be notified via mail of specials and seasonal discounts?      Yes Please      No Thank you

Please take a moment to carefully answer the following questions 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.**

**WE RESERVE THE RIGHT TO REFUSE OR TERMINATE TREATMENT AT OUR DISCRETION**

Have you ever had a professional massage before?      Yes      No

What do you wish to accomplish with massage? (circle all that apply)      Relaxation/Stress Reduction      Pain Relief

Have you had any surgery or hospitalization?

More than 10 years ago:

5-10 years ago:

Less than 5 years ago:

Have you ever been involved in an injury or accident?

More than 10 years ago:

5-10 years ago:

Less than 5 years ago:

Do you consider that you have recovered from these events?

Do you have any chronic, ongoing conditions that you deal with on a regular basis?

Are you sensitive to touch or pressure in any area?

Do you have numbness or stabbing pains anywhere?

Are you currently under the care of a doctor for any reason?

Please list and explain any medications you are currently taking:

\*\*\*\*\*PLEASE COMPLETE BACK OF THIS FORM\*\*\*\*\*

Circle any of the following conditions that you have experienced:

**Skin**

Boils  
Fungal Infections  
Herpes Simplex  
Warts  
Eczema  
Psoriasis  
Skin Cancer  
Other

**Muscle/Skeleton**

Fibromyalgia  
Rheumatoid Arthritis  
Osteoarthritis  
TMJ Dysfunction  
Strains, Sprains or tendonitis  
Carpal Tunnel Syndrome  
Thoracic Outlet Syndrome  
Osteoporosis  
Other

**Nervous**

Depression  
Multiple Sclerosis  
Post Polio Syndrome  
Headaches  
Stroke  
Seizure disorders  
Reduced Sensation  
Sleep Disorders  
Other

**Circulatory**

Anemia  
Thrombophlebitis  
Deep Vein Thrombosis  
High Blood Pressure  
Low Blood Pressure  
Heart Disease  
Varicose Veins  
Clotting Disorders  
Other

**Lymph/Immune**

Edema  
Leukemia/Lymphoma  
HIV/AIDS  
Chronic Fatigue Syndrome  
Lupus  
Allergies (oils, fragrances, foods)  
Allergies (other)  
Other

**Respiratory**

Asthma  
Emphysema  
Sinusitis  
Tuberculosis  
Other

**Digestive/Urinary**

GERD (reflux)  
Ulcers  
Crohn's Disease  
Ulcerative Colitis  
Irritable Bowel Syndrome  
Gallstones  
Cirrhosis  
Hepatitis  
Kidney Stones  
Renal Failure  
Other

**Endocrine**

Diabetes  
Hyperthyroidism  
Hypothyroidism  
Other

**Reproductive**

Breast Cancer  
Endometriosis  
Ovarian Cysts  
Prostate Cancer  
Painful Menstruation  
Breast Augmentation/Reduction  
Are you pregnant?  
Are you nursing?  
Other

Because massage and 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.

Client's Signature \_\_\_\_\_

Date \_\_\_\_\_

**CONSENT TO TREATMENT OF MINOR:** By my signature below, I hereby authorize \_\_\_\_\_  
to administer massage or bodywork techniques to my child or dependent as they deem necessary.

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

## Massage Therapy Informed Consent

I, \_\_\_\_\_, (client) understand that massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive, non-sexual experience of touch.

I understand that massage therapy is not a substitute for medical treatment or medications and that it is recommended that I concurrently work with my Primary Caregiver for any condition that I may have.

Certain medical conditions are contraindications for Massage Therapy. I have informed the Massage Therapist of all my known physical or medical conditions, past or present, and any medication that I am currently taking so that the Massage Therapist can explain any possible contraindications. I will keep the Massage Therapist updated on any changes in my health status.

I am aware that the Massage Therapist does not diagnose illness or disease, does not prescribe course of treatment, and that any information communicated will not be construed as such. I understand that Massage Therapists do not perform spinal manipulations.

I understand that sexual harassment will not be tolerated. If sexually explicit remarks are made or sexual favors are requested or implied, the Massage Therapist will immediately terminate the session. I understand that if the session is terminated for these reasons, that I will be responsible for the full session fee and will be asked not to return for further treatments.

If I experience any physical or emotional pain or discomfort during this session, I will immediately inform the practitioner so that the pressure of the strokes and/or the modalities used may be adjusted to my level of comfort. I also understand that it is within my rights as a client to terminate the session at any point if I so choose.

I have received a copy of the therapist's 'Client and Appointment Booking Policies' (see back of this form).

By signing below I understand and agree to abide by the above statements as well as the 'Client and Appointment Booking Policies'.

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Client Name

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Date

## **Client and Appointment Booking Policies**

1. Payment in the form of cash, check and credit card is accepted and is due at the time services are rendered. A monthly service charge of 1.5% (18% per annum) will be assessed for all balances should any portion of the balance exceed 30 days or more.
2. There will be a \$20.00 fee imposed on returned checks.
3. Clients are to provide a health history (this will be completed during your first session) and updates as necessary.
4. You have the right to consent to any treatment. If at any point you experience physical or emotional discomfort, inform the practitioner immediately, so that the session can be modified if necessary. Understand that you can end the session at any time if necessary.
5. Sessions begin and end at scheduled times. Please arrive 5-10 minutes prior to your scheduled appointment so that your appointment may start promptly on time. Tardiness of more than 15 minutes will be expected to reschedule. Failure to make the scheduled appointment on time will result in a shortened treatment session and client will be charged the full session price.
6. If a cancellation is necessary, please give a minimum of 24 hours notice or you will be charged for the appointment. Emergency cancellations are determined at the discretion of the practitioner.
7. Please do not arrive for your session under the influence of alcohol or illegal drugs.
8. In the event that fees for services are not paid as requested, past due balances may be subject to interest charges. The client will be responsible for any reasonable cost associated with collecting such fees (including attorney and court costs).
9. Sexual harassment will not be tolerated. If sexually explicit remarks are made or sexual favors are requested or implied, the practitioner will immediately terminate the session. In this instance, the client is responsible for the full session fee and will be asked not to return for any further treatments.
10. Be clean, having showered the same day as the treatment. Shower facilities are available for your use.
11. We reserve the right to refuse service or terminate treatment at our discretion.
12. Tipping is up to the discretion of the client, it is not required.