

Client Information

Name _____ Date _____

Street _____ Day Phone () _____

City _____ State _____ Zip _____ Eve Phone () _____

Occupation _____ Date of Birth _____

Emergency Contact Name and Phone _____ () _____

Email _____ Referred by _____

Please answer the questions to the best of your knowledge, to provide a safe effective massage.

Do you have any difficulty lying on your front, back, or side? Yes _____ No _____

If yes, please explain _____

Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?

Please explain _____

What result do you want from your massage sessions? _____

Please check any condition listed below that applies to you:

- | | |
|---|---|
| <input type="checkbox"/> contagious skin condition/disease | <input type="checkbox"/> phlebitis/varicose veins |
| <input type="checkbox"/> open sores or wounds | <input type="checkbox"/> deep vein thrombosis/blood clots/Embolism |
| <input type="checkbox"/> easy bruising | <input type="checkbox"/> recent accident/injury/fracture |
| <input type="checkbox"/> recent surgery/stroke etc? | <input type="checkbox"/> artificial joint(s)/steel rods/metal screws? |
| <input type="checkbox"/> cancer | <input type="checkbox"/> sprains/strains |
| <input type="checkbox"/> current fever/headache/migraine | <input type="checkbox"/> swollen glands |
| <input type="checkbox"/> pregnancy - If yes, how many months? | <input type="checkbox"/> other _____ |

Draping will be used during the session – only the area being worked on will be uncovered.

I _____ (print name) understand that the massage I receive is provided for the purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist to adjust the pressure to my comfort level. I understand a massage therapist is not a doctor and cannot prescribe medications or diagnose medical conditions.

I understand that if I arrive late, my session will end at the original scheduled time so the client following me is not penalized.

I agree to give 24-hour notice for a scheduled session that I can not keep. I am aware that I may be charged the full fee for any missed sessions or for sessions that I do not give 24-hour notice to cancel or reschedule.

I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated to any changes in my profile and understand there shall be no liability on the therapists part should I fail to do so.

Signature of client _____ Date _____