

General Information

Date: _____

Client Name: _____ Birthdate: ____/____/____
Address: _____ City: _____ State: _____ Zip: _____
Phone: (____) _____ - _____ Alt. Phone: _____
Email: _____

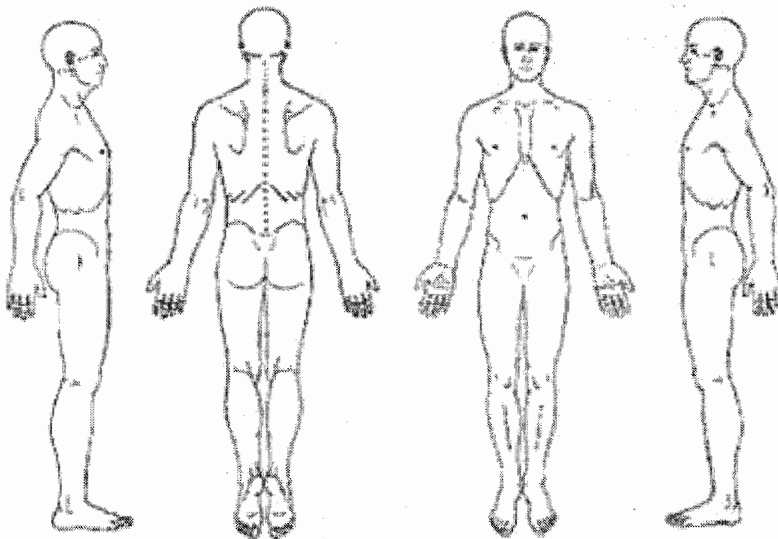
Have you ever had a professional massage? Yes No If so, how recently: _____
Are you involved in any other therapies at this time: Yes No
If so, what type and how often? _____

Could you be pregnant? Yes No Number of weeks: _____
Emergency Contact: _____ Emergency Phone: _____

Chief Complaint:

Reason for appointment/areas of complaint, pain or tension: _____

Do you have persistent pain? Yes No Location: _____
On a scale of 1 to 10, 10 being most painful, how would you rate your pain? _____
When did the pain or tension begin? _____
Do you associate this condition with a specific activity (work, exercise, etc.)? Yes No
If so, please explain: _____



Please Circle any specific areas you would like the massage therapist to concentrate on during the session.

Please describe any other areas of discomfort including tender spots, scars, past injuries or limited range of motion: _____

Do you exercise regularly or participate in any physical arts, activity, or sport?: Yes No

If so, what type and how often? _____
Are you currently taking any medications? For what? Please List: _____

Do you have high/low blood pressure? Yes No Is it controlled by medication? Yes No
Are you allergic to skin oils or lotions? Yes No What type? _____

Please check all conditions that you currently experience or have in the past:

- | | | |
|---|---|---|
| <input type="checkbox"/> Skin Conditions | <input type="checkbox"/> Epilepsy/ seizures | <input type="checkbox"/> Bone Breaks or dislocation |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Acute/Trauma | <input type="checkbox"/> Disc injuries/ Spinal Problems |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Infectious or contagious Disease | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Recent Surgery | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Mental Conditions | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Chronic Heart/ Kidney Disease |
| <input type="checkbox"/> Prosthetic implants, shunt, pacemaker | <input type="checkbox"/> Allergies | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Varicose veins/ Blood clots/ Phlebitis | <input type="checkbox"/> Contact Lenses | |
| <input type="checkbox"/> TMJ | <input type="checkbox"/> Hypertension/ Cardiovascular disease | |
| <input type="checkbox"/> Frozen Shoulder | | |

Financial Agreement/Patient Policy:

*Please arrive on time for your appointments. Please **give at least 24 hours notice** to avoid a late cancellation charge of full treatment fee. Insurance companies do not pay for missed appointments and clients will be charged the full price of service for late or missed appointments. I understand that payment is due at the time of service. I agree to the above terms and authorize my practitioner to bill my credit card for amounts unpaid by insurance or as otherwise specified above. We will never charge this number without giving you prior notice.

Visa or MasterCard accepted (please circle one)

Card No. _____ Exp. date: _____ CVV # (on back): _____

Billing address (if different than personal address):

Address: _____ City: _____ State: _____ Zip: _____

Patient Signature: _____ Date: _____

Client Agreement:

I understand that massage is intended for the purpose of stress management, relief of muscle tension and to promote wellness. I also understand that massage therapists do not diagnose mental or physical illnesses nor do they prescribe medication or treatment for disease. I understand that any sexual overtures will be sufficient grounds to end the massage and that payment for the session will be collected in full. Since a massage therapist must be aware of existing physical conditions, I have stated any pertinent information and will keep my therapist up-to-date prior to any sessions.

Signature _____ Date _____