Client Information

Name:_____

Address:_____ Phone: (_____)_____

City/State/Zip:_____

Email: _____

Birthdate:_____ Employer/Occupation:_____

Emergency Contact:_____ Phone:_____

Referred by (How did you hear about me?):_____

Have you ever received professional massage? Yes/No

What brings you here for treatment today?_____

Should you have special needs please let me know and I will do my best to accommodate you.

CANCELLATION POLICY

Please give 24 hours notice if you need to cancel or reschedule your appointment.

If you are late for your appointment you will receive treatment for the balance of time reserved for you. Should you be unable to keep your appointment, please phone me at 253.370.5533 (even if that means calling at your scheduled appointment time) so that someone else may have the session**.** **If you do not make an effort to let me know that you will not be coming you will be billed the normal fee for the session**, as I must hold the slot open for you until you either come in or phone. Insurance does not cover no-show fees; these charges will be your responsibility. (initial) _____

If you are ill please cancel by calling 253.370.5533, as receiving bodywork while your body is trying to fight off something will only make you feel worse.

Medical History (include date and treatment received)

Surgeries:_____

_____

_____

Accidents/Injuries:_____

_____

_____

List current medications including aspirin, ibuprofen, etc. It is **not** necessary to list supplements.

_____

_____

SKIN
__allergies
__rashes
__athlete's foot
__warts
__other

DIGESTIVE
__constipation
__gas/bloating
__diverticulitis
__irritable bowel syndrome
__other

NERVOUS SYSTEM
__herpes/shingles
__numbness/tingling
__chronic pain
__fatigue
__sleep disorders
__lupus
__other

REPRODUCTIVE
__pregnant
__menstruating
__other

CIRCULATORY
__heart condition
__varicose veins
__blood clots
__high blood pressure
__low blood pressure
__lymphedema
__asthma/breathing difficulty
__sinus problems
__allergies
__other

OTHER
__cancer/tumors
__diabetes
__eating disorders
__depression
__substance abuse

MUSCULO-SKELETAL
__bone or joint disease
__osteoporosis
__bursitis
__fractures
__arthritis
__jaw pain/TMJ dysfunction
__ neck, shoulder, arm pain
__ mid back pain
__ low back/hip/leg pain
__headaches/head injuries
__spasms/cramps/strains
__tendinitis
__fibromyalgia
__other

INFECTIOUS DISEASE
__disease name(s):_____
_____

__I wear dentures
__I wear contact lenses

I understand that massage practitioners do not diagnose illness, disease or any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulation. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.
I have stated all medical conditions that I am aware of and will notify the massage practitioner of any changes in my health status.

SIGNATURE:_____ DATE:_____
(Parent or guardian signature if under 18)