



Name: _____ **Date:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Sex at Birth: Male | Female **Pronoun:** _____ **Date of Birth:** _____
Phone: _____ **Cell:** _____ **Work:** _____
Occupation: _____
Email: _____
Emergency Contact: _____
Emergency Contact Phone: _____ **Relationship:** _____

Have you ever received a professional massage before? Yes _____ No _____

Are you currently seeing a medical specialist? If yes, what for? Yes _____ No _____

Please list all current medications/herbs/supplements/etc: _____

Allergies: _____

Surgeries: _____

Accidents/Illnesses/Injuries: _____

Do You Wear: Contacts _____ Dentures _____ Transdermal Patch (nicotine) _____ IV Port _____

Are there any areas you don't want massaged: _____



For the following, check off the boxes that apply to the best of your ability.

F = Family History | C = Currently Experiencing/Chronic Condition | P = Past Experience

F C P

- Osteoporosis
- Low Back Pain
- Sciatica
- Fatigue/Exhaustion
- Hearing Loss/Deafness
- Urinary Issues
- Edema/Swelling
- Reproductive Issues
- Tinnitus
- Scoliosis
- Numbness/Tingling

F C P

- Migraine/Headaches
- Poor Vision
- Tendonitis/Tendonosis
- Arthritis/Rheumatoid Arthritis
- Sprains/Strains
- Upper Back Pain
- Hip Pain
- Nosebleeds
- Bursitis
- Herniated Disc(s)
- Jaw Pain

F C P

- Insomnia
- Anxiety
- High Blood Pressure
- Low Blood Pressure
- Anemia
- Heart/Vessel Conditions
- Blood Clots
- Lymphedema

F C P

- Lupus
- Reynaud's Syndrome
- Multiple Sclerosis
- Hashimoto's Disease
- Cancer/Tumor(s)
- Herpes/Shingles
- Immuno-compromised
- Fibromyalgia

F C P

- Eating Disorder
- Diabetes
- Knee Pain
- Acid Reflux
- Crohn's Disease
- Diverticulosis
- Varicose Veins

F C P

- Rashes/Eczema/Psoriasis
- Sinus Issues
- Irritable Bowel Syndrome
- Depression
- Asthma
- COPD/Emphysema
- Warts



Are you currently pregnant: _____

If yes, how many weeks: _____

Have you ever been pregnant: _____

Any other medical concerns: _____

Any History Of:

- Drug Addiction
 Caffeine Addiction
 Nicotine Addiction
 Alcohol Addiction
 Sugar/Sweets Addiction

Agreement:

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I understand that payment is due at the time of service, in full, unless agreement has been made otherwise with the massage therapist. If I cannot make an appointment, I understand there is a \$40 charge if I do not provide at least 48 hours of notice; unless it is due to an emergency. Application of this charge is at the massage therapist's discretion.

It is my responsibility to be an active participant in my treatment. I am aware that I should alert my massage therapist to anything that is uncomfortable or painful. I understand that energetic techniques may be used, and that I have the right to request that they not be included for any reason.

Signature

Date