

MESSAGE INFORMATION FORM

NAME _____ DOB: _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

HOME # _____ ALT # _____ EMAIL _____

EMPLOYER _____ OCCUPATION _____

REFERRED BY YELLOW PAGES ADVERTISEMENT FRIEND _____

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE APPROPRIATE BOX

PRIMARY REASON FOR TREATMENT: _____

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a professional massage before? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any skin allergies? <input type="checkbox"/> or skin irritations? <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have arthritis? <input type="checkbox"/> or any joint disorders? <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have high blood pressure? <input type="checkbox"/> or other heart problems? <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have varicose veins? <input type="checkbox"/> or blood clots? <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any spinal problems? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have frequent headaches? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you exercise or participate in any sports?
If so, what kind and how often? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any recent surgeries, broken bones, major accidents, etc..?
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you currently under a doctor's care? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any medical condition of which I should be aware before giving you a massage? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Women only, are you pregnant? |

Provisions of the Massage

During your massage the therapist may use Swedish, deep tissue, cross fiber, trigger point, Myofascial Release or other approved techniques to facilitate the massage. The therapist will massage the necessary body parts to facilitate the massage excluding any contraindication areas. The therapist will not work the breast area without written consent by the client. Proper draping will be used through out the massage. If at any time the client is uncomfortable with the massage the therapist will discontinue the massage.

I have read and understand the questions above and the statements regarding the provisions of the massage.

Client _____ Date _____ Therapist _____ Date _____

CLIENT'S WAIVER

Massage therapy is not a substitute for medical examinations and diagnosis. It is recommended that I see a physician for any physical ailment that I may have. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. Likewise, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor does the therapist perform any spinal adjustments. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all of my known medical conditions and understand that there shall be no liability on the practitioner's part should I fail to do so.

Signature _____ Date _____