

Client History Form

Date: _____

Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____ City/Zip _____

Mobile phone: _____ Email: _____

Referred by: _____

Emergency contact: _____ Phone: _____

Have you ever received professional massage before? No Yes How recently? _____

What kind of pressure do you prefer? Light Medium Firm

List and prioritize your current symptoms/issues: _____

Are there any activities that aggravate your symptoms? (desk job, on your feet, exercise or sport?) _____

Do you have favorite areas for extra massage (head, feet, etc.)? _____

Are there any areas you'd like me to avoid? _____

90 minute treatments may include light abdominal massage. OK? Yes No Let's discuss

I use organic coconut and/or nut oils for massage. Do you have any nut allergies? Yes No

Are you ok with essential oils? (lavender, etc.?) Yes No Let's discuss

Please list any medical conditions that you currently have: _____

Have you had any surgery or treatment for cancer? (lymph nodes removed, chemo, radiation)

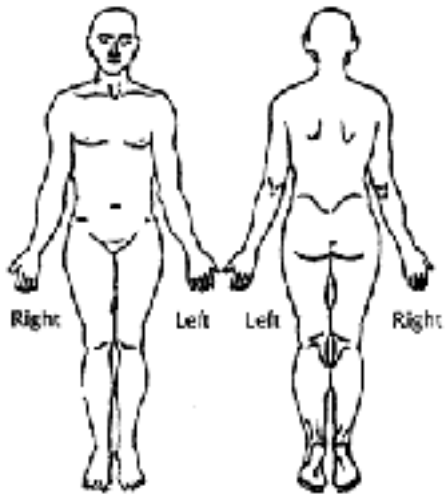
Are you pregnant? Yes No Are you wearing a hairpiece/extensions? Yes No

Are you wearing contacts? Yes No Are you wearing dentures? Yes No

Consent for Treatment

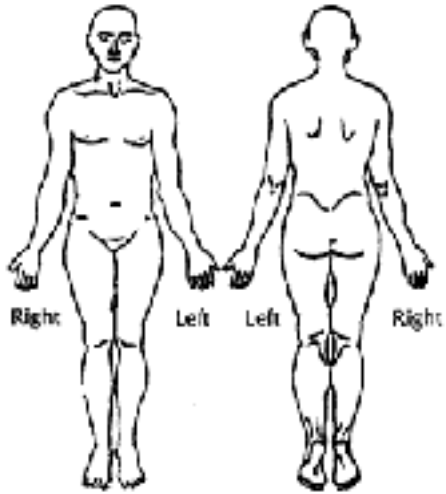
If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a qualified medical specialist for any mental or physical ailment of which I am aware. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____



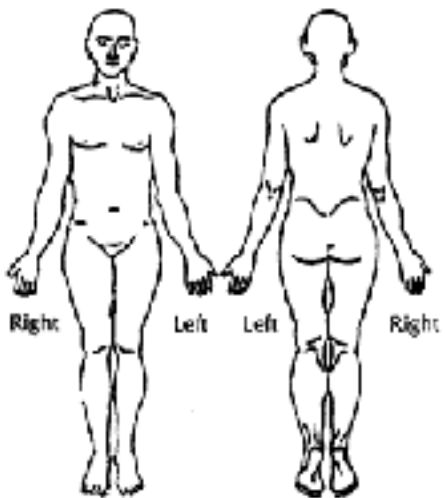
Date: _____

Notes: _____



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