Confidential

CLIENT INFORMATION & RELEASE FORM

NAME: _____

Address: _____

Phone: _____ Date of Birth: _____

Referred By: _____ Occupation: _____

GENERAL & MEDICAL INFORMATION: Email: _____

YES	NO	
_____	_____	Have you ever had a professional massage? Date: _____
_____	_____	Do you experience frequent headaches?
_____	_____	Are you pregnant?
_____	_____	Are you Diabetic?
_____	_____	Do you have high blood pressure?
_____	_____	If yes to above, are you taking any medication for this?
_____	_____	Are you epileptic?
_____	_____	Have you had any surgery? Explain: _____
_____	_____	Do you have any recent injuries, bruises or swelling? _____
		_____
_____	_____	Do you have any tension or soreness in a specific area? _____
		_____
_____	_____	Do you have any numbness or stabbing pains anywhere? _____
		_____
_____	_____	Do you have any other medical/physical condition I should be aware of?
		Heart condition, varicose veins, etc. _____

Date when your symptoms appeared: _____

How often do you have this pain? _____

What makes it better? _____

What makes it worse? _____

What treatments have you received for your condition? Massage / Physical Therapy / Surgery
Acupuncture/ Chiropractic / Medication / Other

What are your expectations/goals for your body for:

This Session_____

Long Term_____

Informed Consent

I hereby request and consent to the performance of Massage Therapy and other modalities and procedures.

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation, stress education, and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that infrequently, a small amount of bruising, and / or soreness may accompany a massage treatment.

I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment; and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of.

I understand that massage therapists/bodyworkers are not qualified to perform spinal or skeletal adjustments, diagnosis, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session(s) given should be construed as such.

Because massage/bodywork is contraindicated (should not be done) under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any change in my medical profile, and understand that there shall be no liability on the practitioner's part should I fail to do so.

It is also understood 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 for the "full" scheduled appointment.

I have read the above consent and understand it.

Payment Policy

I, the undersigned, understand and agree to the payment policy. I acknowledge that payment for all care received is my responsibility. **Payment is due at time of service** unless other arrangements have been made in advance with the office manager. We accept cash, credit cards or checks. **I also understand that a 24-hour cancellation notice is necessary to avoid charges.**

Cancellation Agreement

I look forward to helping you! The time you schedule is reserved just for you. Your treatment schedule is designed for optimal results. Missed appointments will hinder your progress. **The full payment of the massage service will be charged for missed appointments or cancellations without 24 hours notification.** I have read, understand, and agree to the cancellation agreement.

Signed: _____ Date: _____

Practitioner: _____ Date: _____