TODAYS DATE: ________________

GENERAL INFORMATION

NAME: ________________________________ (Check One) MALE FEMALE

ADDRESS: _____________________________________ BIRTHDATE: _________________

CITY: ___________________________ STATE: _______________ ZIP: _________________

PHONE (home):__________________ (work): _______________ (cell): ________________

OCCUPATION: ________________________________

E-MAIL ADDRESS: ____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME: _____________________ PHONE: ________________________

RELATIONSHIP: ______________________________ E-MAIL: _______________________________

HEALTH CARE INFORMATION

APPROXIMATE WEIGHT: ____________ HEIGHT: __________________

PLEASE LIST ANY INJURIES, BROKEN BONES, OR SURGERIES, AND OCCURRENCE DATE: _______________
____
____

ARE YOU CURRENTLY UNDER THE CARE OF A HEALTH PROFFESSIONAL? YES NO

IF YES, WHAT IS HIS/HER NAME? ____

PLEASE LIST ANY MEDICATIONS/VITAMINS/HERBAL SUPPLEMENTS YOU TAKE:
____
____

WHAY TYPE OF EXCERSICE DO YOU DO AND HOW OFTEN? _____________________________________
____
____

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS YOU ARE EXPERIENCING:

EMOTIONAL CHANGES	HEADACHES	SKIN DISORDERS
HYPOGLYCEMIA	PHLEBITIS	PMS
HEART AILMENT	DIABETES	PREGNANCY
INFECTIOUS CONDITION	SLEEPLESSNESS	FLU/COLD/FEVER
KIDNEY AILMENT	ALLERGIES	HIGH BLOOD PRESSURE
CANCER	TMJ SYNDROME	VARICOSE VEINS
CHRONIC/ACUTE PAIN	DIGESTIVE PROBLEMS	ARTHRITIS
NECK/SPINE INJURY	ULCERATED COLON	OSTEOPOROSIS
FIBROMYALGIA	JOINT DISCOMFORT	CARPAL TUNNEL SYNDROME

OTHER: ____
____

I understand that if I experience any pain or discomfort during my session(s), I will immediately inform the massage therapist in order for the pressure and/or stroke to be adjusted to my level of comfort. I further understand massage/bodywork should not be considered a substitute for medical examination, diagnosis, or treatment; I should see a qualified medical specialist for any mental or physical ailment that I experience. I understand the massage therapist is not qualified to perform spinal or skeletal adjustments, diagnose or treat any physical or mental illness, or to prescribe any medications; nothing said during the session(s) should be interpreted as such. Because massage/bodywork should not be done under certain medical conditions, I affirm that I have stated all of my known medial conditions, and have answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile, and understand that there shall be no liability on the massage therapist part should I forget 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.

Cancellation Policy:
I understand that if I fail to give 24 hours notice when cancelling an appointment I may be subject to 50% of the cost of service.

CLIENT SIGNATURE: ________________________________ DATE: ____________________________

PARENT SIGNATURE: _______________________________ DATE: ____________________________

(REQUIRED IF CLIENT IS LESS THAN 18 YEARS OF AGE)

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