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Please print clearly & legibly!!

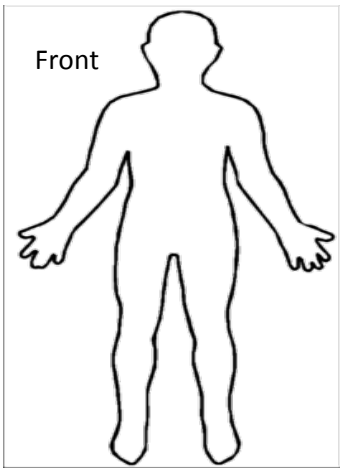
Client Name:_____ M/F DOB_____ Date_____
Home Ph: _____ Cell Ph: _____Texting: Y N
Address_____
City/State/ Zip_____
Occupation_____Email_____
Emergency Contact:_____ Phone:_____
My General Wellness is: __Good __Fair __Poor How Often do you exercise per week _____
Last Chiropractic treatment _____ Reason_____ Result_____
How did you hear about me or who can I thank for the referral: _____
What do you want to accomplish today with your massage?_____

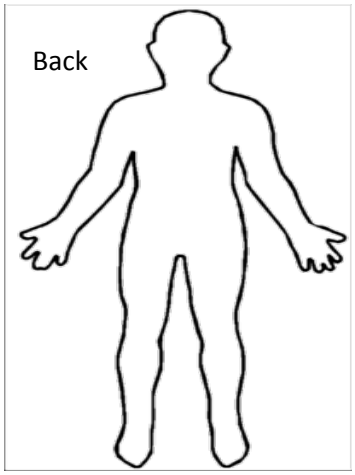
Health Information:

The information on this questionnaire will assist me with your massage as your therapist. All information is kept confidential. Please answer truthfully and circle all that apply:

Skin Rash	Seizures	Diabetes	Bursitis
High/Low Blood Pressure	Fainting	Osteoporosis	Numbness/Tingling
Heart Conditions	Dizziness	Whiplash	Disk Problems
Chest Pain	Light Headed	Stiff Neck	Ticklish Feet
Phlebitis/ Blood Clots	Asthma	Headaches	Sciatica
Bruise Easily	COPD	TMJ/Teeth Grinding	Hip/Knee Replacement

Any pain with movement: Y N Where & Doing what? _____
Have you seen a doctor for the pain? Y N Results: _____
Any Allergies: (Oils, Nuts, Seeds, Medications, Etc.) _____
Any Injuries, broken bones, or surgeries in the last 2 yrs.?_____
Medications: (prescription & nonprescription)_____
_____
Females: Are you Pregnant? Y N; If so how far long? _____ Are you considered high risk? Y N
Circle problem areas:





Client Release Form

I understand this information will be treated confidentially.

I understand the massage therapy given is for the purpose of stress reduction, relief from muscular tension, spasm, or for increasing circulation and energy flow. If I experience any pain or discomfort during this session, I will immediately inform the therapist. In order to maximize the effectiveness and safety of massage sessions, I agree to give feedback during and at the end of my sessions. I understand that I will need to update my therapist on my health and well-being prior to each session.

I understand that massage therapy is a therapeutic health aid and is **non-sexual**. 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. I understand that information exchanged during any massage session is educational in nature and is intended to help me become more familiar with and conscious of my own health status and is to be used at my own discretion. Initials: _____

I understand massage is designed to be a health aid and is in no way to take the place of a doctor's care when a doctor's care is indicated. I understand that a massage therapist does not diagnose illness, disease, or any other physical or mental disorder. I understand that a massage therapist does not prescribe medical treatment or pharmaceuticals or perform any spinal manipulations. It has been made clear to me that massage therapy is not a substitute for medical examinations and/or diagnoses and that it is recommended that I see a physician for any physical ailment(s) that I might have.

I affirm that I have stated all my known medical conditions and have answered all questions honestly. I understand that there shall be no liability on the practitioner's part should I forget to do so.

Client Name (please print) _____

Client Signature_____Date_____

Massage Therapist _____Date_____