

Bodywork Client Information

Name: _____ Phone #: _____
Address: _____ Apt. #: _____
City: _____ State: _____ Zip: _____
Email: _____
Date of Birth: _____ Occupation: _____
Referred by: _____
Emergency Contact: _____ Phone #: _____

General and Medical Information

Y N Have you ever had professional bodywork/massage? If yes, how often and what type?

Y N Are you pregnant? _____

Y N Do you wear contact lenses? _____

Y N Do you have high blood pressure?
If yes, is it under control? _____

Y N Do you suffer from seizure disorders or epilepsy? _____

Y N Are you diabetic? If yes, is your diabetes under control? _____

Y N Have you broken any bones in the past two years?
Which? _____

Y N Do you have cardiac or circulatory problems? Please explain.

Y N Have you ever had surgery? If yes, please explain.

Y N Do you have any other medical conditions or injuries?

Y N Are you currently taking any medications? What for?

Please review this list and **circle** those conditions that have affected your health either recently or in the past:

- | | |
|----------------------------|--------------------------------------|
| arthritis | condition |
| diabetes | diverticulitis |
| blood clots | headaches |
| broken/dislocated bones | heart conditions |
| bruise easily | back problems |
| cancer | high blood pressure |
| chronic pain | insomnia |
| constipation/diarrhea | muscle strain/sprain |
| auto-immune condition* | pregnancy |
| hepatitis (A, B, C, other) | scoliosis |
| skin conditions | seizures |
| stroke | whiplash |
| surgery | chemical dependency (alcohol, drugs) |
| TMJ disorder | |

depression, panic disorder, other psych
(*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

If any of the above needs to be detailed or if there is anything else to share, please do so:

Do you have any of the following today?:

- skin rash
- cold/flu
- open cuts
- severe pain
- injuries/bruises
- anything contagious

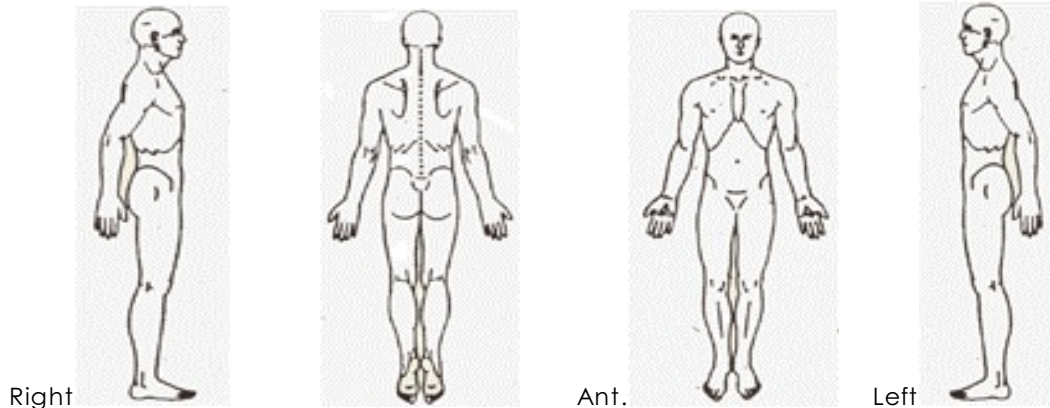
Do you have any allergies to:

Medications _____
Foods (nuts, etc.) _____
Environmental allergens (dust, pollen, fragrances) _____
Reactions to skin care products _____

Are you wearing:

- contact lenses
- hearing aid
- pacemaker
- hairpiece

Please indicate with an (X), if any, the areas in which you are feeling discomfort:



What are your goals/expectations for this therapy session?

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to do.

This may be a need to move or change position sighing, yawning, change in breathing, stomach gurgling emotional feelings and/or expression, movement of intestinal gas, energy shifts, falling asleep, recalling memories.

Information and Suggestions

- Prior to your massage, please remove contact lenses and all jewelry.
- In general, massage is given while you are unclothed. You will be covered with a top sheet throughout your session.
- Massage therapy reduces muscular and mental stress. It may also help correct posture imbalances and improve locomotion. Massage is one of the successful methods of decreasing cellulite if repeated at least twice a month for 6 months.

Massage Client Waiver Form

Please take a moment to read and **initial** the following information:

_____I understand that massage is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow .

_____If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.

_____I understand that the services offered today are not a substitute for medical care.

_____I affirm that I have notified my therapist of all known medical conditions and injuries.

_____I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.

_____This is therapeutic bodywork and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.

_____By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to massage therapy, energy work, and other bodywork.

I have received the policy statement, and have read and agree to the policies therein.

Client name:_____

Client signature:_____

Date:_____

Therapist signature:_____

Thank you and ENJOY!