Client Information and Consultation Form

Name:_____ Date: _____
Last First MI MM/DD/YY

Address:_____
Street Apt.# City State Zip

Home phone:_____ Work phone:_____ e-mail _____

Date of Birth: _____ Emergency Contact:_____
Name Phone #

Occupation:_____

Reason for Appointment: _____

Have you had a professional massage before ? YES NO If "yes", how long ago ? _____

List Current Medications: _____

List any Allergies:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS WITH *"YES" or "NO"*. EXPLAIN IF NECESSARY

Skin problems _____	Arthritis _____	High/Low blood pressure _____
Blood clots _____	Diabetes _____	Varicose veins _____
Seizures _____	Pregnant _____	Circulation disorders _____
Contact lenses _____	Cancer _____	Contagious diseases _____

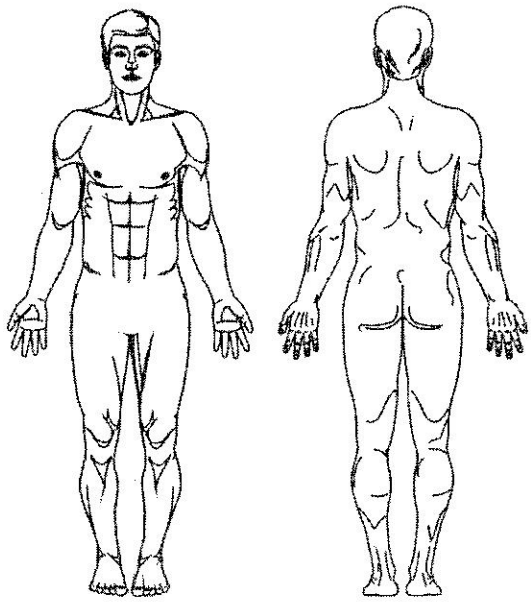
PLEASE LIST ANY OTHER MEDICAL CONDITIONS, MAJOR ILLNESS, BROKEN BONES, SURGERIES, OR ACCIDENTS THAT YOU HAVE HAD WITHIN THE LAST 3 YEARS.

_____

_____

_____

On this diagram please ***circle*** the areas of the body that you feel need the ***most*** attention in the massage session, and place an ***"x"*** over the areas that you wish to have avoided.



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PLEASE INITIAL THE FOLLOWING STATEMENTS: ***Initial***

1) I am aware that draping will be used during the massage session. _____

2) I understand that it is not within the scope of the massage session for the therapist to engage in breast massage of female clients. _____

3) I understand that *my* feedback is an essential element in my treatment, therefore if at any time I should become uncomfortable during the massage, I may bring it to my therapist's attention and request that the session end. _____

4) If I am unable to keep an appointment, I understand that an 8 hour notice is required, otherwise, I will be charged for the time reserved. _____

TO BE COMPLETED BY THE MASSAGE THERAPIST

The following type(s) of massage techniques will be used in the therapy session.

❑ Shiatsu	❑ Trigger Point	❑ Reiki
❑ Swedish	❑ Deep Tissue	❑ Sports
❑ Stretching	❑ Accupressure	❑ Hot Stone
❑ Reflexology	❑ Craniosacral	❑ Myofascial
❑ Pregnancy	❑ Other _____	

PLEASE READ THE FOLLOWING STATEMENTS, THEN SIGN AT THE BOTTOM OF THE PAGE

I have read and I fully understand this form in its entirety. If at any time there are changes in the information given or in my condition, I will notify my therapist, and update this form before receiving additional massages.

The massage treatment given here is for the sole purpose of stress reduction, relief from muscle tension or spasm and to increase circulation and energy flow.

The Massage Therapist does not diagnose or prescribe for medical illness, disease, or any other physical or mental disorder.

The Massage Therapist does not do spinal manipulations. Massage Therapy is not a substitute for medical examination or diagnosis, and it is recommended that a physician be seen for any ailment that you may have.

It is the Client's (your) responsibility to explain and discuss all physical conditions with the Massage Therapist so that they may do their job. Your Massage Therapist is an independent professional and is solely responsible for your treatment.

Client Signature **Massage Therapist Signature**