

BODY N SOUL MASSAGE: CONFIDENTIAL CLIENT INFORMATION & HEALTH HISTORY

Name: _____ D.O.B. _____
Address: _____ City: _____ St: _____ Zip: _____
Phone: (H) _____ (W) _____ (C) _____ Marital Status: _____
Email: _____ Physician: _____
Referred By: _____ Height: _____ Weight: _____ Anniversary: _____
Occupation: _____ Employer: _____
In Case of Emergency: _____ Phone: (____) _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? Yes No If so, how recently? _____
What do you hope to accomplish from today's massage? _____

If you answer "yes" to any of the following questions, please explain as clearly as possible.

- | | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you frequently suffer from stress?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have diabetes?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you experience frequent headaches?
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from arthritis?
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing contact lenses?
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing dentures?
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing hearing aid(s)?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have high blood pressure?
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you taking high blood pressure meds?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from epilepsy or seizures?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from joint swelling?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have varicose veins?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any contagious disease?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have osteoporosis?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have scoliosis? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any allergies?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you bruise easily?
<input type="checkbox"/> Yes <input type="checkbox"/> No Any broken bones in the past 5 years?
<input type="checkbox"/> Yes <input type="checkbox"/> No Any injuries in the past 5 years?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have cardiac or circulatory problems?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from back pain?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have numbness or stabbing pain?
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you sensitive to touch or pressure in any area?
<input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had surgery? If so, for what: _____

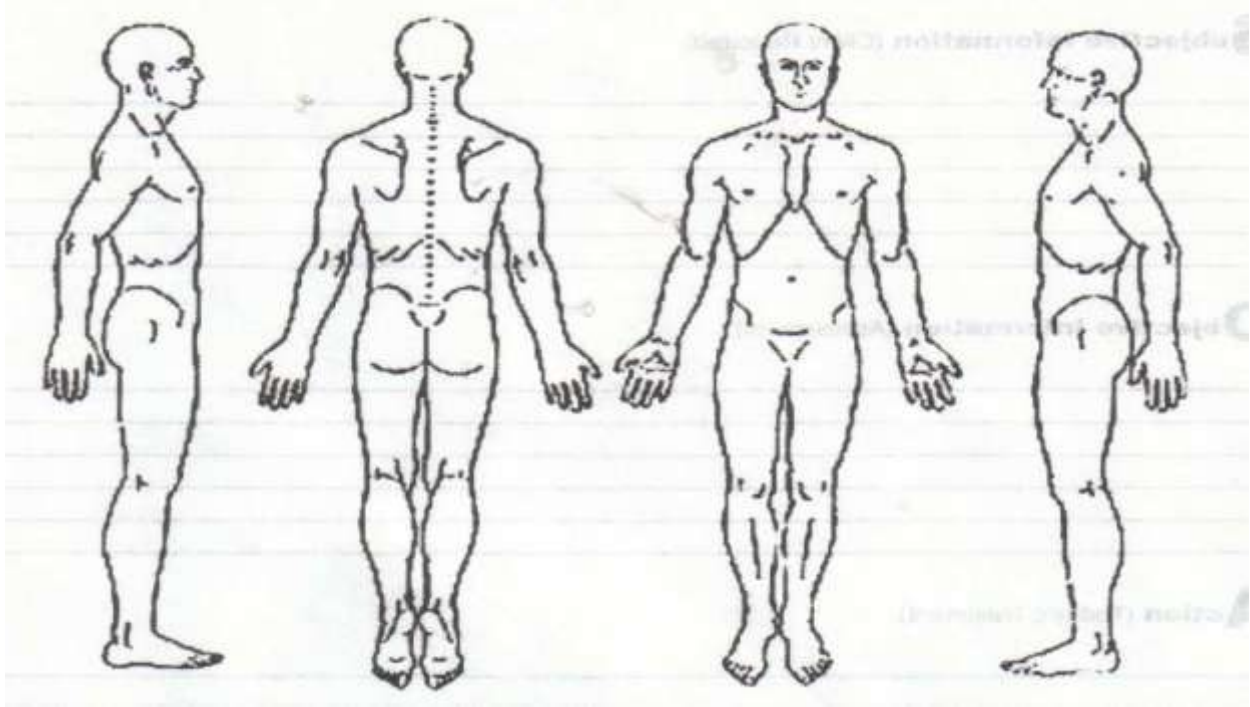
<input type="checkbox"/> Yes <input type="checkbox"/> No Other medical condition, or are you taking any medications I should know about?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have chronic tension or soreness in a specific area? Please specify: _____
_____ |
|---|---|

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation 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 further understand that massage or 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 of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed 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 changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. 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. Scheduled appointments will start and end on time. All cancellations and/or rescheduling of appointments require at least 24 hours notice or a \$25 fee will be charged.

Client Signature Date: ____/____/_____
Consent to treatment of minor: I authorize massage be performed on my above named child or dependent as deemed necessary by massage therapist.
Signature of parent/guardian: _____ Date: ____/____/_____

Name: _____ Date: ____/____/____

On the following pictures, please **circle the problem areas** you are having **today** and the **sensation**: ex: Pain, tightness, knots, tingling, stiffness, sore, numbness, etc.



- **TODAY**, what type of pressure would you like on a scale of 1 to 10 ?

Lighest 1 2 3 4 5 **|** Deep tissue starts here 6 7 8 9 10 Deepest

- Any areas you would **NOT** like massaged today? _____

- **Currently**, are you experiencing any of the following conditions?

Cold or flu Fever Inflammation
 Infection Open Wounds/Sores Contagious Disease

- Any comments: _____

Client Signature: _____ Date: _____

STOP and return form to the massage therapist ☺