1000 South Fifth Street, Easley SC 29640 864-306-0336

Date ____________________

Print Name ____

Home Phone ______________________ **Cell Phone** ________________________

Address ____ **City**_______________ **State** _____ **Zip**___________

Email _____________________________________ How did you hear about us? ____________________________

How would you prefer to be contacted with promotions & appointments reminders?

Email _______ Phone _______ Neither _______

Have you had a massage before? Yes / No If so, when was your last massage? ___________________________

What are your reasons for being here? (Circle any that apply)

Health and wellness relaxation stress pain injury headache pregnancy

Occupation: _______________________ DOB: _____________ Emergency Contact: __________________________

Emergency Contact Phone #: _____________________________ Relationship: ________________________________

Health History

CHECK ✓ by all conditions that you currently have and ✕ all previous conditions.

__AIDS	__Arthritis	__Diabetes	__Fibromyalgia	__Shingles
__Hernia/Rupture	__Hay fever	__Broken bones	__Lymph congestion	__Sciatica
__Heart Problems	__HIV	__Lupus	__Osteoporosis	__Blood clots
__Stroke	__Cancer	__Insomnia	__Migraines	__Spinal injuries
__ Neck pain	__Blood pressure H/L	__ Headaches	__Osteoarthritis	__Panic attacks
__Infections	__Thyroid issues	__Vertigo	__Varicose veins	__Major fall
__Spastic colon	__Epstein-Barr	__Chemical sensitivities	__ Sleeping disorder	__Irritable bowel

List all medical problems currently being treated by a medical doctor:

____

____

List all medications: ____

Note additional information: ____

____

List all allergies: ____

Surgeries, Accidents, or Illnesses: ____

____

If you have ever experienced any of the following in the past or currently, explain
Pain, numbness, tingling, swelling, fatigue, etc.: ____

____

Check the box that best describes each of these concerns below:

	Frequently & Severe	Frequently	Rarely	None
Migraines				
Headaches				
Neck Pain & Tightness				
Diarrhea				
Blurred Vision				
Acid Reflux				
Tender Areas				
Open Cuts/Sores				
Skin Allergies				
Chest Pains				
Varicose Veins				
High Blood Pressure				
Low Blood Pressure				
Swelling Feet/Ankles				
Leg Cramps				
Phlebitis/Thrombosis				
Difficulty Relaxing				
Difficulty Sleeping				
Sinus Problems				
Easily Out of Breath				

Health & Wellness Information

On a scale of 1-10 (10 being high, 1 being low) rate the following:

Amount of negativity in your life ______ personal stress ______

How many glasses of water do you drink each day? _______

Please Circle One:

Have you ever had motion sickness? Yes / No

Left (L) or Right (R) Hand Dominant?

Introvert (not talkative) or Extrovert (very talkative)?

Are you a primary caregiver of someone else? Yes / No

Have you recently lost a job or changed careers? Yes / No

Have you had a major relationship change? Yes / No

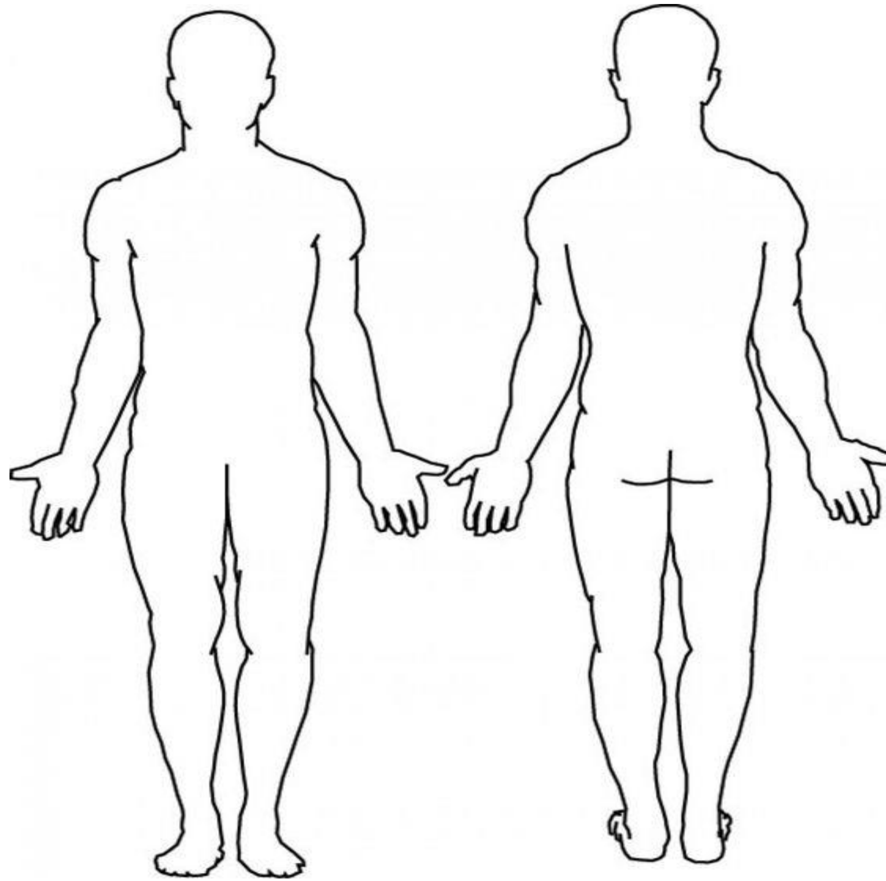
What movements cause or aggravate your pain? **Check all that apply**.

___ Standing ___Sitting ___Driving ___Bending ___Stooping ___Kneeling ___Lifting

___Other, Explain ____

On the figures below please **Shade** in any areas of muscle or joint pain/stiffness.

Circle areas where you have had pain for some time.



Front Back

Please **CIRCLE** what your pain level is right now? **0= No pain** to **10= Worst pain of your life**

0 1 2 3 4 5 6 7 8 9 10

Disclaimer and Release of Liability

I, ____, understand and agree to the following statements:
(Please Print Name)

- Information provided to me, written or stated, by ETM is for Informational and educational purposes only. This information is not meant to substitute for the advice provided by my medical provider and/or personal physician, or any other medical professional.

- I understand and voluntarily accept any risk associated with massage.

- I understand that if I have, or suspect that I have, a medical problem I will promptly contact my health care provider. It is my responsibility to immediately inform a therapist of any changes, pre-existing conditions, limitations, or specific sensitivities. I must personally make sure to update my client information file.

- Information and suggestions regarding dietary supplements have not yet been evaluated by the Food and Drug Administration and are not intended to diagnose, treat, care, or prevent any disease. I absolve and hold harmless ETM (to include independent contractors and employees) from any liability/responsibility

- I release ETM from all loss and damage to myself and those that I bring into association with ETM. This serves as my consent to release my medical records to ETM if we request them.

- ETM/Easley Therapeutic Massage & Wellness Center is also referred to as ETM, Easley Therapeutic Massage and/or Wendy Law (May include independent contractors and employees) and can be understood to be the same sometimes. This release applies to all the previously named.

- It is my responsibility to immediately notify the therapist if I have any discomfort or have concern during the session.

- Appointments/ massages must be cancelled 24 hours prior to appointment time.
- No show Appointments will incur full service fee, same day cancellations will incur a $35 fee.

Signature ____ Date___/___/______

Witness ____ Date ___/___/______