Client Consultation- Massage

Date: _____/_____/_____

Name: _____

Date of Birth MM/DD/YY: _____/_____/_____

Address: _____

City: _____State:_____Zip:_____

Cell Phone: (_____) _____-_____ E-mail address: _____

Referred by: _____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

1. Have you had a professional massage before? O No O Yes If yes, how often do you receive massage therapy?_____

2. Do you have any difficulty lying on your front, back, or side? O No O Yes

   If yes, please explain_____

3. Do you have any allergies to oils, lotions, or ointments? O No O Yes

   If yes, please explain_____

4. Do you have sensitive skin? O No O Yes

5. Are you wearing contact lenses O No O Yes / Dentures O No O Yes / Hearing aid O No O Yes

6. Do you sit for long hours at a workstation, computer, or driving? O No O Yes

   If yes, please describe _____

7. Do you perform any repetitive movement in your work, sports, or hobby? O No O Yes

   If yes, please describe_____

8. Do you experience stress in your work, family, or other aspect of your life? O No O Yes

   If yes, how do you think it has affected your health?

   Muscle Tension O No O Yes / Anxiety O No O Yes / Insomnia O No O Yes / irritability O No O Yes / other_____

9. Is there an area of the body where you are experiencing tension, stiffness, pain or other discomfort? O No O Yes

   If yes, please identify_____

10. Do you have any particular goals in mind for this massage session? O No O Yes

    If yes, please explain_____

Medical History:

11. Are you currently under medical supervision? O No O Yes

    If yes, please explain_____

12. Do you see a chiropractor? O No O Yes If yes, how often? _____

13. Are you currently taking any medication? O No O Yes

    If yes, please list _____

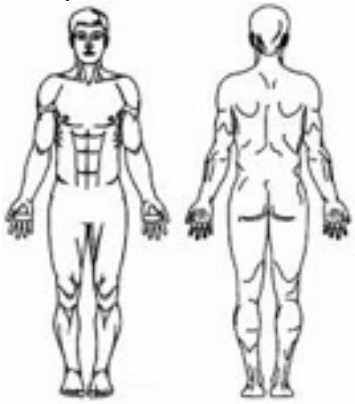
14. Please check any condition listed below that applies to you:

O contagious skin condition
O open sores or wounds
O easy bruising
O recent accident or injury
O recent fracture
O recent surgery
O artificial joint
O sprains/strains
O current fever
O swollen glands
O allergies/sensitivity
O heart condition
O high or low blood pressure
O circulatory disorder
O varicose veins
O atherosclerosis
O phlebitis
O deep vein thrombosis/blood clots
O joint disorder/rheumatoid arthritis osteoarthritis/tendonitis
O osteoporosis
O epilepsy
O headaches/migraines
O cancer
O diabetes
O decreased sensation
O back/neck problems
O Fibromyalgia
O TMJ
O carpal tunnel syndrome
O tennis elbow
O pregnancy / if yes, how many months? _____

Please explain any condition that you have marked above _____
_____

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?_____
_____

16. Circle any specific areas you would like the massage therapist to concentrate on during the session:



17. Are you comfortable with having massage on the following areas?

Gluteal	O No O Yes
Pectoral	O No O Yes
Scalp	O No O Yes
Face	O No O Yes
Abdomen	O No O Yes
Feet	O No O Yes

Draping will be used during the session – only the area being worked on will be uncovered. Clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 18.

I, _____ (print name) understand that the massage 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 therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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 that I am aware of. I understand that massage therapists 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 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Future Appointments/Contact:

May I call/text you at your cell phone number to confirm future appointments? O No O Yes
May I contact you via mail/email about future promotions and news? O No O Yes

We appreciate your business. So that we can best serve all our clients, please be advised of these policies.

CONFIRMATION

A confirmation email &/or text will be sent 72 hours before your scheduled appointment. If the appointment is not confirmed within 24 hours of your appointment start time the scheduled time will not be held.

ARRIVAL TIME

Please aim to arrive 10 minutes before your scheduled appointment time. If you arrive after your scheduled appointment time, it may not be possible to extend the time available for your booked service; if your service is shortened due to your late arrival, you will be charged the full cost of the service.

CHANGING YOUR APPOINTMENT

24 hours notice is required to reschedule or cancel a booked appointment. If you reschedule, cancel or miss your scheduled appointment you will be charged 50% of the service cost if less than 24 hours before your appointment.

Client Signature: _____Date:_____

Massage Therapist: _____ Date: _____