

Your Inner Space

Massage Client Information

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

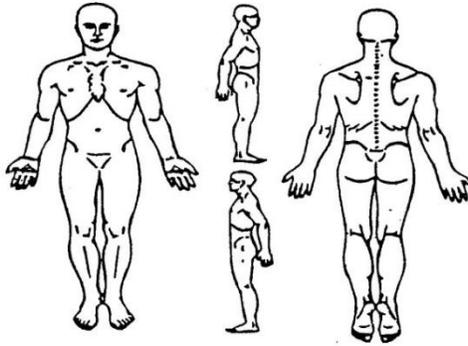
Phone: _____ Email: _____

Occupation: _____ Referred By: _____

Emergency contact name & number: _____

Please check here if you would like to receive the Your Inner Space Newsletter. _____

Are you currently in pain or experiencing any discomfort? If so, please briefly explain and indicate those areas below. Mark **X** for pain, **O** for discomfort, and **||** for numbness/tingling: _____



Describe any chronic pain/tension _____

What makes it better? _____

What makes it worse? _____

Are you currently under the care of a physician, chiropractor or alternative medicine practitioner? If yes, what are you being treated for? _____

Please list any medications (prescription or non-prescription), vitamins and supplements you are currently taking: _____

What specific areas would you like for me to focus on or stay away from? _____

What do you hope to accomplish with this massage? (relaxation, decrease back pain, increase flexibility, etc.)

What kind of pressure do you prefer? _____

How frequently and for how long do you exercise and what do you do? Include sports, pilates, yoga, gardening and/or other physical activities: _____

Please check any of the following that apply to you.

Condition/Complaint	Past	Present	Condition/Complaint	Past	Present
Headaches			Numbness in arms, legs, Hands or feet		
Type:			Strains/Sprains		
Stress			Neurological problems		
Asthma			Spinal Problems		
Cold hands/feet			Herniated/Bulging Discs		
Swollen ankles			Osteoarthritis		
Sinus Conditions			Arthritis		
Frequent Colds			Anxiety		
Allergies (specify above)			Depression/Panic		
Loss of smell/taste			Sleep Disturbance		
Skin Conditions			Loss of Memory		
Painful/Swollen Joints			Whiplash		
Auto-immune disorder			Bruise Easily		
Cancer			Constipation/Diarrhea		
Varicose Veins			Contact Lenses		
Blood Clots/DVT			Dentures/Partials		
Heart Problems			Hemorrhoids		
Pacemaker			Surgeries		
High/Low BP			Muscular Tension		
Diabetes			Sciatica		
Epilepsy or Seizures			Pregnancy		
Fainting Spells					

Further explanation of any condition or other information: _____

The following sometimes occurs during massage; they are normal responses to relaxation. Trust your body to express what it needs:

- ☺Need to move or change positions
- ☺Sighing, yawning, change in breath
- ☺Stomach gurgling
- ☺Emotional feelings and/or expressions
- ☺Movement of intestinal gas
- ☺Energy shifts
- ☺Falling asleep
- ☺Memories

- I understand the treatment here is not a replacement for medical care.
- As such, the therapist/practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform any spinal manipulations (unless specified under his/her professional scope of practice)
- I understand that the treatment is not a substitute of medical treatments and/or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have.
- I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.
- I understand that payment is due at the time of treatment unless arrangements have been made otherwise. .
- **I agree to give at least 24 hours notice of cancellation of appointment, otherwise will be expected to pay for session PLEASE INITIAL _____**

Client signature _____ Date _____