DRAGONFLY

Medical Massage Therapy

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Client Information

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone #: _____ Secondary Phone #: _____

Emergency Contact: _____ Phone #: _____

Email: _____ (We never share your email address!)

Website: _____

Employer: _____ Occupation: _____

How did you find out about us? (Referral, Friend, Colleague, Article, Online, etc.)

_____

Reason for your visit? (i.e. Relieve discomfort, Manage pain, Maintain health)

_____

Have you ever had professional massages before? No: ___ Yes: ___ then how long ago? _____

Are you pregnant or trying to get pregnant? No: ___ Yes: ___ then how far along are you? _____

Is there anything specific that you want to discuss?

_____

PLEASE MARK IF YOU HAVE/HAD ANY OF THE FOLLOWING CONDITIONS:

__ Heart Conditions __ High Blood Pressure __ Diabetes
__ Skin Disorders __ Immune Disorders __ Respiratory Disorders
__ Vascular/Blood Disorders __ Stomach Disorders __ Cancer
__ Arthritis __ Neuropathies __ Broken Bones
__ Headaches __ TMJ Syndrome __ Sciatic Pain
__ Neck or Shoulder Aches/Pains __ Back or Chest Aches/Pains __ Leg or Foot Aches/Pains
__ Breast Augmentation __ Edema __ Dentures
__ Wear Contacts __ Wear Glasses __ Allergies
__ Allergies to oils/scents __ Herniated/Bulging/Degenerative Discs
__ Radiation and/or Chemotherapy treatment. If Yes: When last _____ and for how long? _____

Please inform us of any health care professionals you have seen for any of the conditions mentioned above:
_____
Please inform us of all prescription medications, past and present:
_____

Do you smoke? No: ___ Yes: ___ then how many packs a day? _____
Do you drink alcohol? No: ___ Yes: ___ then how much a day? _____
Do you drink caffeine? No: ___ Yes: ___ then how much a day? _____
Do you drink soda? No: ___ Yes: ___ then how much a day? _____
Do you eat chocolate? No: ___ Yes: ___ then how much a day? _____
Do you use a lot of salt? No: ___ Yes: ___ then how much a day? _____
Exercising and/or stretching routines: No: ___ Yes: ___ then also provide the following:
Type of exercise/stretching: _____ Days per week: _____ Hours per day: _____

Are there any other medical conditions, issues or concerns (including injuries or surgeries) that we should be aware of before proceeding with the appointment/session:
_____

Please read the following, initial each paragraph and sign below:

___ Be aware that our Licensed Massage Therapists have wide variety of Advanced Training. Techniques to be used include Neuromuscular, Myofascial Release, Trigger Point, Swedish, Visceral manipulation, Manual Lymphatic drainage, Cupping, Range of Motion, Stretching, KinesioTaping.

___ Body parts to be treated include face, neck, scalp, shoulders, arms, hands, back, buttocks, hip flexors, legs, and feet. Therapists may treat muscles of the chest and ribcage; however they do not engage in massage of breast tissue.

___ Our Massage Therapists utilize only conservative draping during our sessions. If I (the client) feel uncomfortable for any reason I may ask to end the session.

___ I understand that the Massage Therapist does not diagnose illness, disease, or any other physical or mental disorder, nor perform spinal adjustments. Massage therapy is not a substitute for medical examinations and/or diagnosis. It is recommended that I see a physician for any physical ailment that I might have. I understand that Massage Therapy given here is for the purpose of, but not limited to: Fulfilling a prescription of a treating physician for a medically necessary condition, for relief from muscular spasm or fascial tension, to improve circulation.

___ It is imperative that Massage Therapists are aware of past and existing physical conditions. I (the client) have stated all my known medical conditions, and take it upon myself to keep the Massage Therapist(s) updated on my physical health.

___ I (the client) will respect the time of my Massage Therapist(s) and other clients. I agree to honor my scheduled appointments and arrive on time, barring any unforeseen emergency. I understand that if I Cancel later than 4 hours prior to my appointment, I agree to pay HALF the cost of my appointment. If I do NOT SHOW, I agree to pay the FULL price of the appointment.

Client: Name (print): _____ Date (mm/dd/yyyy): _____
Signature: _____

Therapist: Name (print): _____ Date (mm/dd/yyyy): _____
Signature: _____