Name: _____ Phone:(Day)_____ Phone:(Eve) _____
Address: _____
City/State/Zip: _____
Email: _____ Date of Birth: _____ Occupation: _____
Emergency Contact: _____ Phone: _____
How did you hear about PCfulwaves Therapeutic Massage? _____

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

Date of Initial Visit: _____

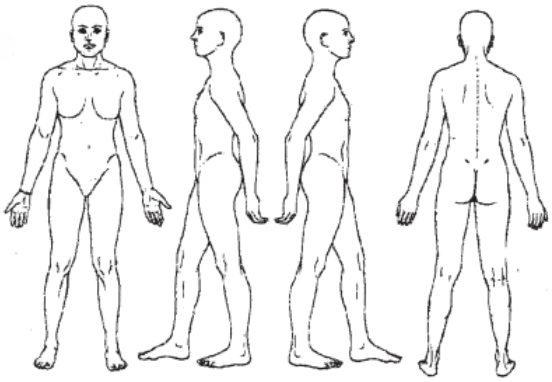
1. Have you had a professional/therapeutic massage before? ☐Yes ☐No
   If yes, how often do you receive massage therapy? _____
2. Do you have any difficulty lying on your front, back, or side? ☐Yes ☐No
   If yes, please explain: _____
3. Do you have sensitive skin or skin allergies to oils (with scent), lotions, or ointments? ☐Yes ☐No
   If yes, please explain: _____

   *Organic coconut oil is used during my sessions, please note if this is a problem.
4. Are you wearing any of the below items that will need to be removed prior to your session?

   ☐ contact lenses
   ☐ dentures
   ☐hearing aid
5. What types of repetitive actions/movements, if any, do you perform throughout your day?
   i.e. Job, use of technology, sports/hobbies
   *Please describe*_____
6. On a scale of 1-10, where do you find your level of stress? _____
   Does your stress cause you to experience any of the following:

   ☐ muscle tension
   ☐anxiety
   ☐insomnia
   ☐irritability
   ☐other _____

Circle any specific areas you would like the massage therapist to focus on during the session:



Medical History

In order to plan a massage session that is safe and effective, I need some general information about your medical history:

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

2. Please list any pharmaceutical drugs that you take and reason. (Most pharmaceutical drugs cause dehydration which can affect your massage session)
   _____
   _____

3. Please check any conditions listed below that apply to you:

   ☐ Contagious skin condition
   ☐ Open sores or wounds
   ☐ Easy bruising
   ☐ Recent injury or surgery
   ☐ Artificial joints
   ☐ High or low blood pressure
   ☐ Current fever/swollen glands
   ☐ Cough
   ☐ Blood clots
   ☐ Epilepsy
   ☐ Cancer
   ☐ Joint disorder/rheumatoid arthritis/osteoporosis

   Please explain any condition that you have marked above: _____

   _____

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

   _____

Professional Conduct & Boundaries Policy

Scope of Service: Massage therapy is strictly therapeutic and non-sexual.
Right to Stop: Either the client or the therapist may stop the session at any time for any reason.
Draping Standard: The client remains properly draped with a sheet at all times; only the specific area being worked on is uncovered.
Inappropriate Behavior: Any illicit or sexually suggestive remarks, advances, or behavior will result in immediate termination of the session, and full payment will be expected.

I, _____ 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.

Signature of client: _____ Date: _____