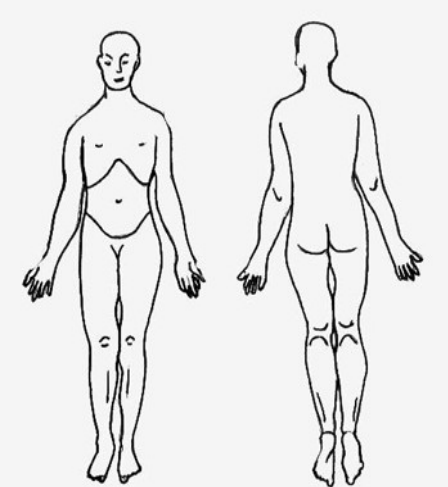


# Client Health Record - Massage

## CLIENT INFORMATION

NAME:		DATE:
PREFERRED NAME / NICKNAME:		
ADDRESS:		
CITY:	STATE/ZIP CODE:	
HOME PHONE:	CELL PHONE:	
EMAIL ADDRESS:		
DATE OF BIRTH:	AGE:	GENDER: M      F
<input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED		
OCCUPATION:		
HOW DID YOU HEAR ABOUT OUR OFFICE?		

## MESSAGE INFORMATION

HAVE YOU EVER HAD A PROFESSIONAL MASSAGE?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
WHAT TYPE OF PRESSURE DO YOU PREFER?		
<input type="checkbox"/> LIGHT <input type="checkbox"/> MEDIUM <input type="checkbox"/> FIRM		
ARE THERE ANY AREAS THAT YOU WOULD <b><u>NOT</u></b> LIKE WORKED ON?		
CIRCLE ANY AREAS YOU WOULD LIKE TO CONCENTRATE ON:		
		

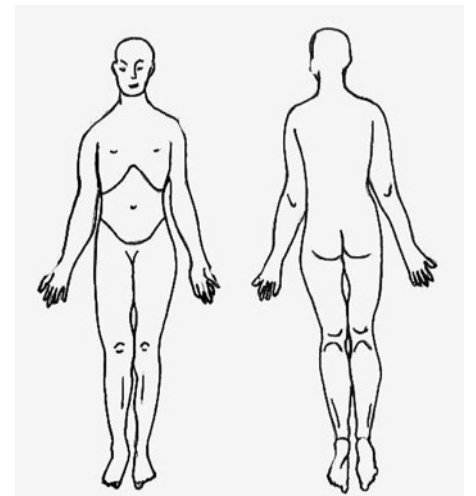
## REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:		
WHEN DID THIS CONDITION BEGIN?		
HAVE YOU SEEN A DOCTOR(S) FOR THIS CONDITION?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
DOCTOR'S NAME AND SPECIALTY:		
TYPE OF TREATMENT:		

PLEASE LIST ANY OTHER CONDITIONS YOU FEEL WE SHOULD KNOW ABOUT, EVEN IF UNRELATED:
--

WRITE THE LETTERS ON THE PICTURE BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW:

A = ACHE  
B = BURNING  
N = NUMBNESS  
O = OTHER  
P = PINS AND NEEDLES  
S = STABBING



CLIENT NAME:  
DATE:

## HEALTH HISTORY

HAVE YOU HAD OR ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?

☐ **DENY ANY ISSUES**

- |  |  |
|--|--|
| <input type="checkbox"/> ACUTE PAIN                  | <input type="checkbox"/> HEADACHES / MIGRAINES     |
| <input type="checkbox"/> ALLERGIES / SENSITIVITIES   | <input type="checkbox"/> HEART CONDITION           |
| <input type="checkbox"/> ARTHRITIS: TYPE _____       | <input type="checkbox"/> HIGH / LOW BLOOD PRESSURE |
| <input type="checkbox"/> ARTIFICIAL JOINT / DISORDER | <input type="checkbox"/> HIV                       |
| <input type="checkbox"/> BLOOD CLOTS                 | <input type="checkbox"/> INFECTIOUS CONDITION      |
| <input type="checkbox"/> CANCER: TYPE _____          | <input type="checkbox"/> LUPUS                     |
| <input type="checkbox"/> CARPAL TUNNEL SYNDROME      | <input type="checkbox"/> MULTIPLE SCLEROSIS        |
| <input type="checkbox"/> CHRONIC PAIN                | <input type="checkbox"/> OPEN SORE / WOUND         |
| <input type="checkbox"/> CIRCULATORY DISORDER        | <input type="checkbox"/> OSTEOPOROSIS              |
| <input type="checkbox"/> CONTAGIOUS SKIN DISORDER    | <input type="checkbox"/> PTSD / PANIC / ANXIETY    |
| <input type="checkbox"/> CURRENTLY PREGNANT          | <input type="checkbox"/> SCOLIOSIS                 |
| <input type="checkbox"/> DECREASED SENSATION         | <input type="checkbox"/> SPINA BIFIDA              |
| <input type="checkbox"/> DEPRESSION                  | <input type="checkbox"/> STROKE                    |
| <input type="checkbox"/> DIABETES                    | <input type="checkbox"/> SWOLLEN GLANDS            |
| <input type="checkbox"/> EASY BRUISING               | <input type="checkbox"/> TENDONITIS                |
| <input type="checkbox"/> EPILEPSY                    | <input type="checkbox"/> TMJ                       |
| <input type="checkbox"/> FIBROMYALGIA                | <input type="checkbox"/> VARICOSE VEINS            |

☐ OTHER: \_\_\_\_\_

☐ OTHER: \_\_\_\_\_

INJURIES:

☐ **DENY ANY ISSUES**

- |   |   |
|---|---|
| <input type="checkbox"/> BACK / NECK INJURY | <input type="checkbox"/> SEVERE FALL        |
| <input type="checkbox"/> FRACTURE           | <input type="checkbox"/> SOFT TISSUE INJURY |

☐ OTHER: \_\_\_\_\_

☐ OTHER: \_\_\_\_\_

LIST PRESCRIPTION MEDICATION / VITAMINS:

## LATE ARRIVAL / CANCELLATION

WE VALUE YOUR TIME AND STRIVE TO PROVIDE THE HIGHEST QUALITY CARE DURING EVERY APPOINTMENT. TO HELP US MAINTAIN THAT STANDARD, WE KINDLY ASK THAT YOU REVIEW THE FOLLOWING POLICY:

**LATE ARRIVALS:** IF YOU ARRIVE LATE, YOUR SESSION MAY BE SHORTENED IN ORDER TO STAY ON SCHEDULE FOR OTHER CLIENTS. **THE FULL SESSION FEE WILL STILL APPLY** REGARDLESS OF THE ACTUAL TIME USED.

**CANCELLATIONS & RESCHEDULING:** PLEASE PROVIDE AT LEAST 24 HOURS' NOTICE TO CANCEL OR RESCHEDULE YOUR APPOINTMENT. CANCELLATIONS WITH LESS NOTICE MAY BE SUBJECT TO A LATE CANCELLATION / NO SHOW FEE OR FULL SESSION CHARGE.

**NO CALL / NO SHOWS:** CLIENTS WHO MISS THEIR APPOINTMENT WITHOUT NOTICE WILL BE CHARGED THE FULL SESSION AMOUNT.

THANK YOU FOR YOUR UNDERSTANDING AND FOR HELPING US RESPECT EVERYONE'S TIME.

## MESSAGE PACKAGE POLICY

MESSAGE PACKAGES ARE **NON-REFUNDABLE**.

PACKAGES REMAIN **VALID WITH ANY OF OUR LICENSED MESSAGE THERAPISTS**.

WHILE SPECIFIC THERAPIST AVAILABILITY MAY CHANGE, WE ARE COMMITTED TO PROVIDING THE SAME HIGH-QUALITY CARE AND SERVICE.

PACKAGES MAY BE **TRANSFERRED TO A FAMILY MEMBER OR FRIEND** IF YOU ARE UNABLE TO USE THEM.

ALL PACKAGES MUST BE USED WITHIN **12 MONTHS** OF PURCHASE.

## INFORMED CONSENT

I UNDERSTAND THAT THE MESSAGE I RECEIVE IS PROVIDED FOR THE BASIC PURPOSE OF RELAXATION AND RELIEF OF MUSCULAR TENSION. IF I EXPERIENCE ANY PAIN OR DISCOMFORT DURING THE SESSION, I WILL IMMEDIATELY INFORM THE THERAPIST SO THAT THE PRESSURE AND/OR TYPE OF STROKE MAY BE ADJUSTED TO MY LEVEL OF COMFORT. I UNDERSTAND THAT MESSAGE IS NOT A SUBSTITUTE FOR MEDICAL EXAMINATION, AND THAT MESSAGE THERAPISTS ARE NOT QUALIFIED TO DIAGNOSE MEDICAL CONDITIONS, PERFORM ANY SPINAL MANIPULATIONS OR PRESCRIBE TREATMENTS. I HAVE STATED ALL KNOWN MEDICAL CONDITIONS AND ANSWERED ALL QUESTIONS, WRITTEN AND VERBAL, HONESTLY. I AGREE TO KEEP THE MESSAGE THERAPIST UPDATED WITH ANY CHANGES IN MY MEDICAL PROFILE AND UNDERSTAND THAT THERE SHALL BE NO LIABILITY TO THE THERAPIST IF I FAIL TO DO SO.

CLIENT NAME (PLEASE PRINT):

RELATIONSHIP TO CLIENT:

SIGNATURE:

DATE:

## EMERGENCY CONTACT

NAME:

PHONE NUMBER: