NAME_____ DATE_____

ADRESS_____

BIRTHDAY_____ PHONE NUM._____

EMERGENCY CONTACT NAME AND NUMBER_____

How often do you receive a professional massage? _____

Do you have any Allergies or sensitivities? _____

What are your goals for this therapeutic massage treatment?

_____

Are you currently seeing a medical practitioner? If yes, why?

_____

_____

List any medication you take and how often:

_____

_____

Please mention dates of any surgeries and accidents for the last 5 years.

_____

_____

_____Your treatment is 100% therapeutic, I understand that if you experience any pain or discomfort during this treatment I will immediately inform, the therapies to adjust to my level of comfort. I am aware that the therapies can't prescribe or treat any physical or mental illness and should not be performed under certain medical conditions.

_____I affirm that I have stated all my known medical conditions and agree to keep the practitioner updated as to any changes.

____I understand that any illicit or sexually suggestive remarks will immediately be reported to the Sahuarita law enforcement authorities; Clients wear underwear and present a clean body to the treatment.

____The cancellation fee of 35.00 dollars will apply within less than 24 hrs. notice; 60.00 dollars no show no call. The client will pay at the next appointment.

Client Signature _____