Lunas Masahe
Criselda White Lic. MT129702
14010 US Highway 183 N. Suite 416 Rm. 8 Austin TX 78717
Phone: (512) 817-3008
Email : LMT @lunasmasahe.com

Client Contact Information

Client Name: ____ Date: ___________
Date of Birth: _________________ Gender: ___________ Cell Phone: ___________________

Address: ____

Email: ________________________________Profession:____

How did you hear about Lunas Masahe? ________________Spouse Name: _____________________________

Email: ____ Cell Phone:___________________________

Can we send deals and information about Lunas Masahe to you and to your spouse? Yes ( ) No ( )

If yes, which way would you prefer? ( ) Text ( ) Mail ( ) E-mail

Daily Habits:

Have you ever had an aesthetics treatment before? ( ) yes When)_________ ( ) No

Do you use contact lens? ( ) yes ( ) No

Sun exposure? ( ) yes ( ) No Sunscreen? ( ) yes ( ) No

Do you smoke? ( ) yes ( ) No How many cigarettes per day? __________________________

Do you drink alcohol ( ) Yes ( ) No How often?___________________

Bowel Movements? ( ) 1-2/ week ( ) 3-4/ week ( ) 1-2/ day ( ) 3x/day

Sleep quality? ( ) good ( ) Regular ( ) Bad How many hours per night?___________________-

How much water do you drink per day?_(oz)______________

How about your appetite? ( ) good ( ) regular ( ) bad How many meals per day? _______________

Do you exercise? ( )yes ( ) No

What type of exercise?_____________________________________How many days/week?_________

So you take any contraceptives? ( ) Yes ( ) No if yes, which one?(s)______________________________

How old were when your first menstrual cycle?____________________________

Are you pregnant? ( ) yes ( ) No

Have you had any previous births? ( ) Yes ( ) No How many ? _________ When? ________________________

AESTHETIC AND SURGICAL HISTORY

Do you have any dental implants? ( ) yes ( ) No If yes, please specify____

Have you ever made any aesthetic treatment? ( ) yes ( ) No If yes, please specify________________________________

Plastic surgery ( ) yes ( ) No If yes, which type and when____

Medical Surgery? ( ) yes ( ) No Which type and when?____

____

How do you feel today? ____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):
____
____

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No Explain:
____
____

Bodywork History

Have you ever received professional massage/bodywork before? Yes（ ）No（ ）

How recently? ___________________________________

What types of massage/bodywork do you prefer? ___________________________________

What kind of pressure do you prefer? Light Medium Firm

What are your goals/expected outcomes for receiving massage/bodywork?
____

Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes（ ）No（ ）

Do you have a physician referral/prescription? Yes（ ）No ( )

Physician/Health-care___________________________________

Provider name: __________________________ **Phone:** ____________________

List the medications you currently take:
____
____

Healthcare Contact Information: ____

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment?
____

Circle any of the following health conditions that you currently have (If you are unsure, please ask): blood clots, infections, congestive heart failure, contagious diseases, pitted edema Please answer honestly, as massage may not be indicated for the above conditions. Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received: Current Past Muscle or joint pain ____________________________________

Current Past Muscle or joint stiffness ____________________________________

Current past Numbness or tingling ____________________________________

Current past Swelling ____________________________________

Current Past Bruise easily ____________________________________

Current Past Sensitive to touch/pressure ____________________________________

Current Past High/Low blood pressure ____________________________________

Current Past Stroke, heart attack ____________________________________

Current Past Varicose veins ____________________________________

Current Past Shortness of breath, asthma ____________________________________

Current Past Neurological (e.g. MS, Parkinson's, chronic pain)

Current Past Epilepsy, seizures ____________________________________

Current Past Headaches, Migraines ____________________________________

Current Past Dizziness, ringing in the ears ____________________________________

Current Past Digestive conditions (e.g. Crohn's, IBS) ____________________________________

Current Past Gas, bloating, constipation ____________________________________

Current Past Kidney disease, infection ____________________________________

Current Past Arthritis (rheumatoid, osteoarthritis) ____________________________________

Current Past Osteoporosis, degenerative spine/disk ____________________________________

Current Past Scoliosis ____________________________________

Current Past Broken bones ______________________________________

Current Past Allergies ______________________________________

Current Past Diabetes ______________________________________

Current Past Endocrine/thyroid conditions ______________________________________

Current Past Depression, anxiety ______________________________________

Current Past Memory Loss, confusion, easily overwhelmed ______________________________________

Comments:

____

____

Consent for Treatment If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork 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 of which I am aware. I understand that massage/bodywork practitioners 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/bodywork 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: ____ Date: ____________

Parent or Guardian Signature (in case of a minor): ____________________________________ Date: ____________