

PLEASE PRINT LEGIBLY

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (H) _____ (W) _____ (C) _____

Email: _____ Who referred you? _____

Emergency Contact _____ Phone: _____

Age: _____ Height: _____ Weight: _____ DOB: _____ Sex: M / F

◆ Have you had a professional massage before? Yes No Last massage session: _____

◆ Do you have any allergies to oils, lotions or ointments? Yes No

If yes, explain _____

◆ Are you wearing contacts dentures a hearing aid ?

◆ What is your occupation? _____

Do you sit for long hours at a computer, workstation or driving? Yes No

◆ Do you perform any repetitive movements in your work, sport or hobby?

◆ Do you experience stress in your work, family or other aspect of your life? Yes No

If yes, how do you think it has affected your health?

muscle tension anxiety insomnia irritability other: _____

◆ What are your goals for today's session/reason for seeking massage therapy?

◆ Are you currently under a doctor's care/medical supervision for any reason? Yes No

If yes, explain _____

◆ Do you see a chiropractor? Yes No For what condition/diagnosis? _____

◆ Do you take any medications or dietary supplements? Yes No Please list & reason:

_____ for _____

_____ for _____

_____ for _____

◆ List all car accidents, approximate dates and brief description:

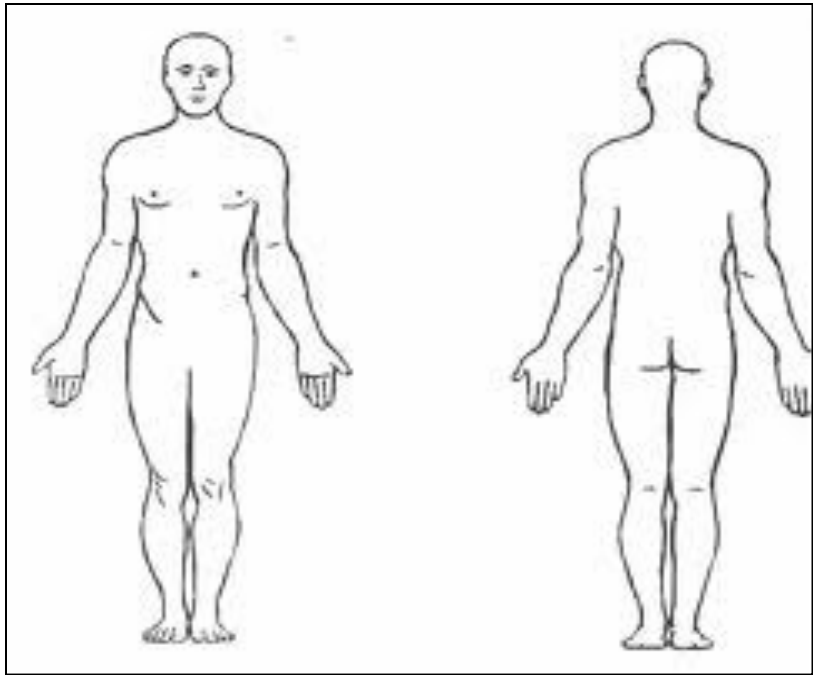
Please mark all current or past conditions:

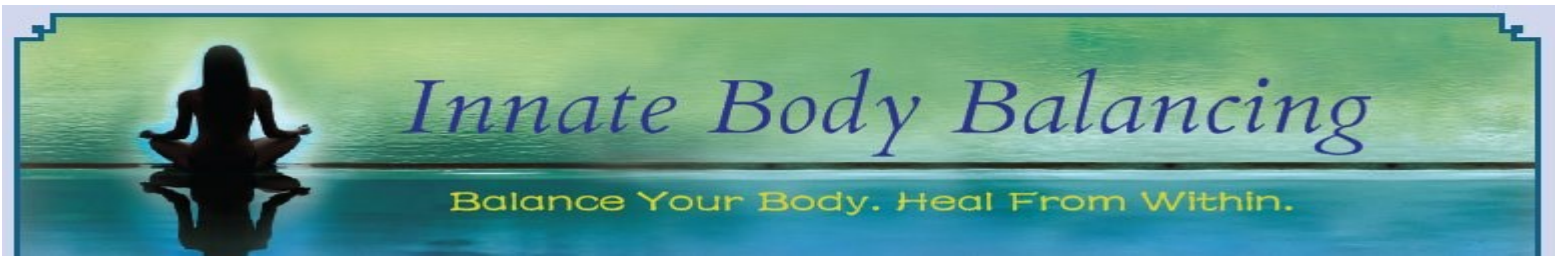
- Abdominal/Digestive
- ADD/ADHD
- Allergies
- Anxiety
- Arthritis
- Asthma/Respiratory/Lung
- Athletes Foot
- Blood Clots
- Cancer
- Chronic Pain
- Circulatory/Heart Cond.

- Constipation
- Depression
- Diabetes
- Dizziness/Fainting/Vertigo
- Fatigue
- Fibromyalgia
- Headaches/Migraines
- Hearing Problems
- Hernia
- Heart Attack/Disease
- Hepatitis
- High Blood Pressure
- HIV/AIDS
- Jaw Pain/TMJ pain
- Low Blood Pressure

- Muscle/Bone Injury
- Numbness/Tingles
- Pregnancy
- Rash
- Sinus Problems
- Sleep Difficulties/Insomnia
- Spinal Disorders
- Strains/Sprains
- Stroke
- Vision Problems
- Varicose Veins
- Whiplash
- Other _____

Indicate on the figures below with an X areas that you experience pain, discomfort or would like addressed.





By signing below I agree to the following policies & procedures :

Arrival time: Please arrive five minutes early for your appointment to get cozy. The time set aside for your appointment is completely yours. If you are late to your session, we will make the most of the allocated time. The session will end at the time scheduled and full cost of the session applied.

Canceling your appointment: If you cannot make your scheduled appointment, please offer 24 hours notice. Please call (no e-mail) should you need to cancel within 24 hours.

Not showing up for your appointment: If you do not show for your appointment, you will be charged the full cost of the session.

Payment: is due at time of service. I accept cash, local checks and all major credit cards. Please make checks out to Shannon Ditzel. I do not provide billing for insurance, but will gladly provide you with a receipt if you would like one.

Sexual Conduct: Massage therapy is strictly therapeutic. If a client behaves in a sexual manner at any time, the session will be terminated immediately, full payment expected, and the client denied any future appointments. Law enforcement will be notified if deemed appropriate.

If I cancel your appointment: If I need to cancel your appointment for any reason within 24 hours of the scheduled time, you will receive a discounted rate at your next appointment. I hope I never have to cancel, but emergencies and illness happen.

Times when massage isn't beneficial: If a client presents with signs and/or symptoms of illness that contraindicate massage (fever, undiagnosed rash, contagious infection, new cold, etc.), the session will be re-scheduled. This is to protect the health of both the client and the therapist. Drugs and alcohol are contraindicated before and after a massage.

Health Intake form: To ensure safe, customized sessions, the client must fill out a health intake form before treatment. It is the client's responsibility to relay all health information so the therapist can modify treatment where necessary. Client agrees to notify therapist of any change in health conditions/status. Client will provide documentation if necessary from physicians, chiropractors, physical therapist, etc, allowing clearance for massage for certain conditions.

Confidentiality: The client's records and sessions will be kept confidential and will not be shared with anyone without the client's written consent except when subpoenaed by a court of law.

I'm not a doctor and only occasionally a miracle worker: Massage serves as a therapeutic tool to enhance well-being. Massage is not a substitute for medical treatment or to replace the care of a licensed physician.

Client Name

Date