Name _____ **EMAIL** _____
Address _____ City/State/Zip _____
Phone: Home_____ Cell_____ Birthday ___/___/___
Occupation _____ Referred to This Office By _____
In Case of Emergency Please Contact _____Phone_____

General and Medical Information

Y N Have you ever had a massage? If yes, how often? _____

Y N Are you pregnant? If yes, how far along are you? _____

Y N Are you sensitive to touch/pressure in any area? (ticklish?) _____

Y N Are you allergic or sensitive to any oils (essential oils, nut oils, scents)? If yes, please list:

Y N Have you ever been diagnosed or suffered from blood clots? _____

Y N Are you taking any blood thinning or blood clotting medications? If yes, please list:

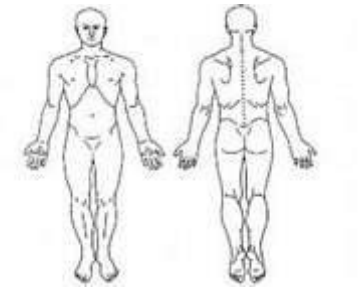
List of current medications and reason: _____

Indicate Areas of Pain/Tension - MAJOR COMPLAINT:
On a scale from 1-10, 10=highest, rate your levels of:
Stress __ ____ Pain ___ ___ Energy ___ ___
How did your symptoms begin and when did they start? -
_____
What have you done for relief? _____
Is the condition getting better/worse? _____

Please check all that apply:

☐ Skin condition-rash, warts, hives, skin cancer, other _____
☐ Lymphatic condition-swollen gland, nasal congestion, lymph edema
☐ Joint problems/stiffness-arthritis, sacroiliac problems, TMJ, other: _____
☐ Bone Condition-osteoporosis, fracture, other _____
☐ Headaches
☐ Recent injury or accident-whiplash, sprain, bruise,
☐ Circulatory Condition-high blood pressure, varicose veins, blood clots
☐ Numbness/Tingling, Sciatica
☐ Tendonitis, Bursitis
☐ Diabetes

Please mark in the diagram above any areas where you have discomfort.



Client Waiver Form

If I experience pain or discomfort during the session, I will immediately inform my therapist so that ROM/pressure can be adjusted to my level of comfort. I will not hold my therapist and the **Destination Massage** responsible for any pain or discomfort I experience during or after the session.

_____

I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

_____

I affirm that I have notified my therapist of all known medical conditions and injuries.

_____

I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.

_____

I understand that massage is entirely therapeutic and non-sexual in nature.

_____

By signing this release, I hereby waive and release my therapist and the **Destination Massage** from any and all liability, past, present, and future relating to massage therapy.

_____

We kindly ask that you give us a 24 hour notice if you need to cancel or reschedule your appointment. In the event that you need to cancel or re-schedule with less than 24 hour notice we will have to keep a CREDIT CARD number on file for future appointments. If you "NO SHOW" or cancel again, we will have to charge the credit card on file a missed appointment fee of $20.

_____

I have received the policy statement, and have read and agree to the policies therein.

Client name:_____ Date:_____

Client signature:_____

Therapist signature:_____