Massage Therapy Client Information

Name:____________________________Telephone:________________Date of Birth: _________________

Address: ____

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In case of emergency:_________________________________Telephone: _____________________________

Please check all of the following conditions that apply and explain:

____ Allergies ______________________	____ Fatigue	____ Sensitive to touch
____ Arthritis	____ Fibromyalgia	____ Sinusitis
____ Back Pain	____ Headaches	____ Skin Disorders
____ Blood Clots	____ Heart Condition	____ Stomach Disorders
____ Bursitis	____ Hepatitis	____ Stress
____ Circulatory Problems	____ Herniated Disc	____ Tension or Soreness
____ Constipation	____ High Blood Pressure	____ TMJ Dysfunction
____ Contact Lenses	____ HIV	____ Varicose Veins
____ Diabetes	____ Numbness/Stabbing Pain	____ Other-Describe Below
____ Diarrhea	____ Pregnant	

Medical conditions not listed above: ____

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Current Medications: ____

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Surgeries: ____

If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Because a massage therapist must be aware of any existing physical conditions that I may have, I have listed all my known medical conditions and physical limitations and I will inform my massage therapist of any changes in my physical health.

I understand and agree that: (1) the massage therapy that I am given is for the purpose of stress reduction, relief from muscular tension or spasm and/or for improving circulation; (2) that a massage therapist neither diagnoses illness, disease or any other medical, physical or mental disorder, nor performs any spinal manipulations; (3) I am responsible for consulting a qualified physician for any physical ailments that I may have; (4) that health and accident insurance policies are an arrangement between an insurance company and myself, and that this office will help prepare any necessary reports to assist me in making collection from the insurance company.

I agree that all services rendered to me are charged directly to me and I am responsible for payment unless prior arrangements have been made. **I agree to pay for all scheduled appointments that I am unable to keep unless I notify my therapist at least 24-hours in advance.**

Signature____Date_____________________