NAME: PHONE:

ADDRESS:

CITY: STATE: ZIP:

DATE OF BIRTH: EMAIL:

HOW DID YOU HEAR ABOUT US?

HOW LONG SINCE YOUR LAST MASSAGE/REFLEXOLOGY SESSION?

WHAT IS YOUR OCCUPATION?

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU ARE CURRENTLY OR RECENTLY EXPERIENCED.

| | | |
|---|---|---|
| ___ACCIDENT | ___COLD HANDS/FEET | ___PREGNANCY |
| ___AIDS/HIV | ___DIABETES | ___SCIATICA |
| ___ALLERGIES | ___DIZZINESS | ___SEIZURES |
| ___ARTHRITIS | ___FIBROMYALGIA | ___SKIN CONDITION |
| ___ASTHMA | ___HEADACHE/MIGRANE | ___SPRAIN/STRAIN |
| ___BLOOD CLOTS | ___HEART DISEASE | ___STROKE |
| ___BRUISE EASILY | ___HIGH/LOW BLOOD PRESSURE | ___VARICOSE VEINS |
| ___CANCER | ___PLANTAR FASCIITIS | __WHIPLASH |

DO YOU HAVE ANY OTHER HEALTH CONCERNS NOT MENTIONED ABOVE?

PLEASE LIST ALL MEDICATIONS, INCLUDING OVER THE COUNTER, WHICH YOU ARE CURRENTLY TAKING OR HAVE TAKEN IN THE PAST 24 HOURS.

BY SIGNING BELOW YOU ACKNOWLEDGE THAT YOU HAVE READ THE FOLLOWING STATEMENT:

CERTAIN MEDICATIONS REQUIRE RELEASE FROM YOUR MEDICAL DOCTOR BEFORE MASSAGE THERAPY CAN BE RECEIVED. IF YOU ARE TAKING ONE OF THESE MEDICATIONS WE MAY NOT BE ABLE TO PERFORM MASSAGE UNTIL BACK SPACE RECEIVES A RELEASE FORM FROM YOUR PRIMARY CARE PHYSICIAN. WE TAKE YOUR HEALTH VERY SERIOUSLY AND NEVER WANT TO CAUSE YOU HARM.

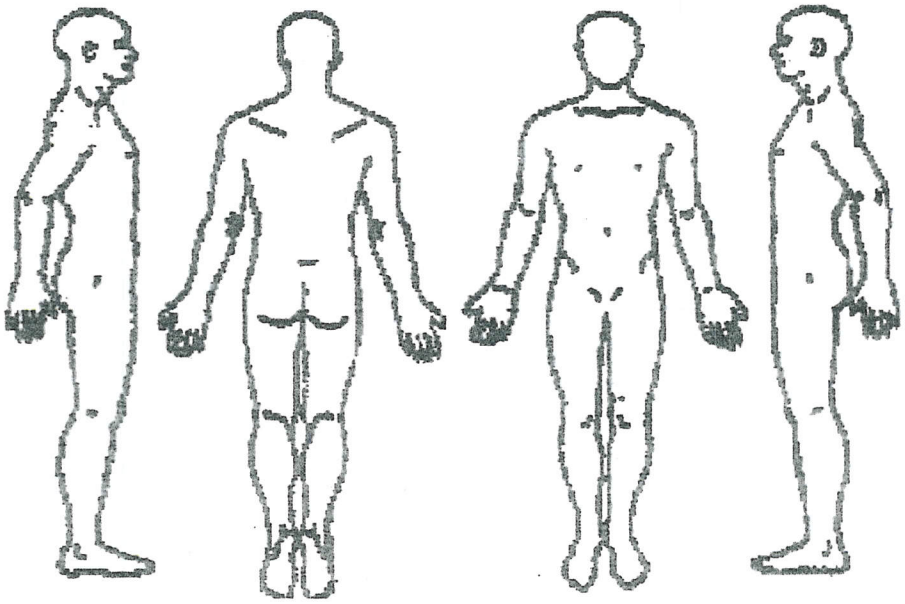
Client Signature Date

OVER →

Consent to treat a minor: By signing below I give my permission for the above mentioned minor to receive therapeutic massage.

Parent/Guardian Signature Date

PLEASE USE THIS PAGE TO MARK AREAS OF PAIN OR DISCOMFORT:



BY SIGNING BELOW I HEREBY STATE THAT I HAVE ANSWERED THE MEDICAL PORTION HONESTLY AND TO THE BEST OF MY KNOWLEDGE. I FURTHER UNDERSTAND THAT, THOUGH THERAPEUTIC, MASSAGE THERAPY IS NOT A SUBSTITUTE FOR MEDICAL TREATMENT. I AM AWARE THAT THE MASSAGE THERAPIST DOES NOT DIAGNOSE OR PRESCRIBE MEDICATION. I FURTHER RELEASE THE MASSAGE THERAPIST FROM ANY LIABILITY FROM HARM CAUSED DUE TO THE OMISSION OF ANY MEDICAL INFORMATION. I ALSO UNDERSTAND THAT THIS IS A THERAPEUTIC MASSAGE AND IS NOT A SEXUAL SERVICE. ANY SEXUAL ADVANCES WILL RESULT IN THE IMMEDIATE TERMINATION OF THE SESSION.

SIGNATURE DATE THERAPIST SIGNATURE DATE

PARENT/GUARDIAN IF CLIENT IS UNDER 19