Health & Harmony
Massage Therapy

~Where Healing Begins~

Client Information

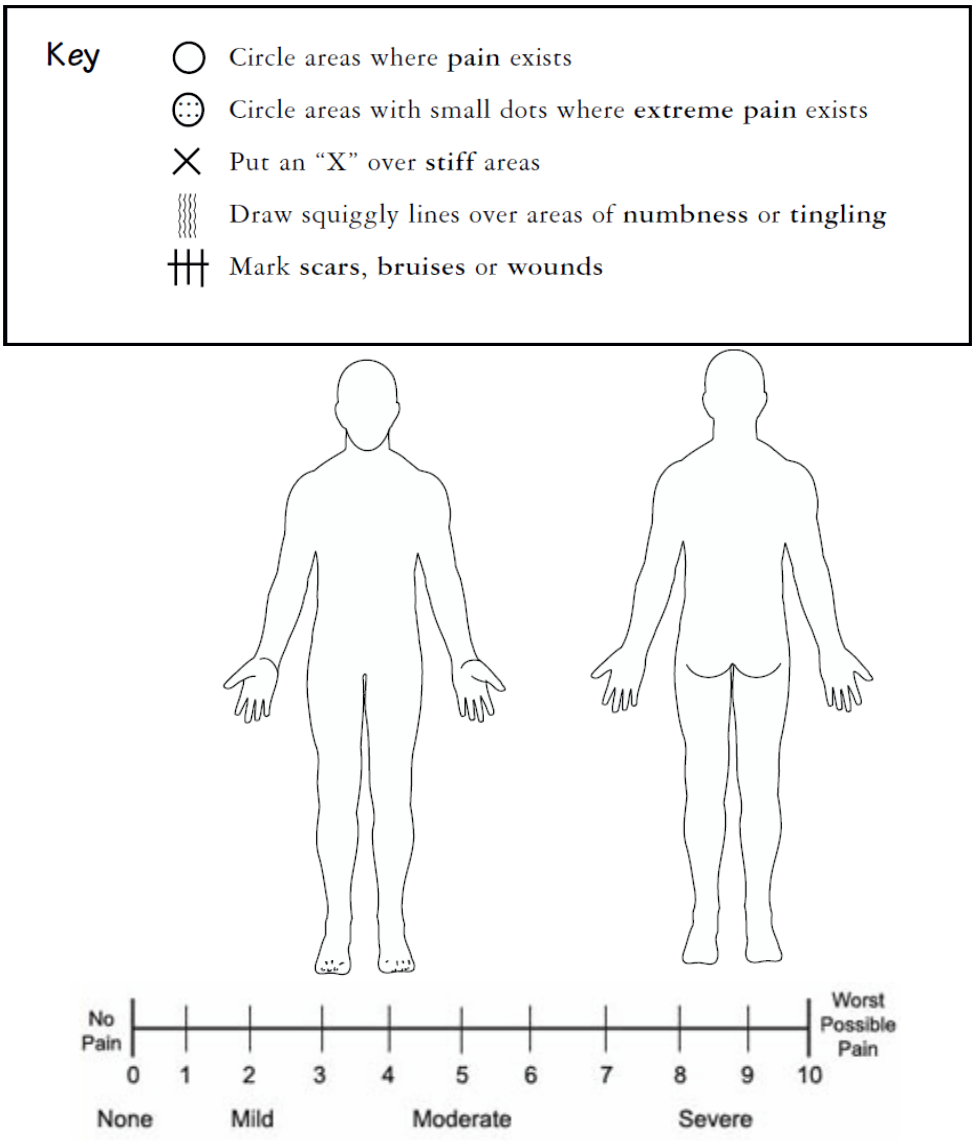
Name_____ ☐ Male ☐ Female DOB_____
Address_____ City_____ State_____ Zip_____
Primary Phone_____ E-mail_____
Occupation_____ Referred By_____
In case of emergency_____ Phone_____
Health Insurance Carrier_____ Physician_____

Have you ever experienced a professional massage? ☐ Yes ☐ No How recently?_____
What kind of pressure do you prefer? ☐ Light ☐ Medium ☐ Firm
What are your goals for this session?_____

☐ Yes ☐ No Do you frequently suffer from stress?
☐ Yes ☐ No Do you have frequent headaches?
☐ Yes ☐ No Do you bruise easily?
☐ Yes ☐ No Are you pregnant?
☐ Yes ☐ No Do you wear contacts?
☐ Yes ☐ No Are you wearing dentures?
☐ Yes ☐ No Do you have varicose veins?
☐ Yes ☐ No Do you have high blood pressure?
☐ Yes ☐ No Do you have blood clots?
☐ Yes ☐ No Do you have any cardiac problems?
☐ Yes ☐ No Do you have diabetes?
☐ Yes ☐ No Do you suffer from epilepsy or seizures?
☐ Yes ☐ No Do you have any Infectious or contagious diseases?
☐ Yes ☐ No Do you have osteoporosis?
☐ Yes ☐ No Do you exercise or participate in any sports?
☐ Yes ☐ No Do you suffer from depression or anxiety? (circle)
☐ Yes ☐ No Do you have pain which radiates down legs and arms?

☐ Yes ☐ No Do you have any skin problems or allergies aside from seasonal?_____
☐ Yes ☐ No Do you have arthritis or any joint swelling? Where?_____
☐ Yes ☐ No Have you ever had cancer? If so what kind?_____
☐ Yes ☐ No Any broken bones or injuries in the past two years? Where?_____
☐ Yes ☐ No Do you have numbness or stabbing pains? Where?_____
☐ Yes ☐ No Are you sensitive to touch or pressure in any area? Where?_____
☐ Yes ☐ No Do you have spinal problems?_____
_____
☐ Yes ☐ No Have you had any surgeries in the past five years? Dates?_____
_____
☐ Yes ☐ No Do you have any other medical condition that I should be aware of before giving you massage therapy?_____
☐ Yes ☐ No Are you taking any medications I should know about?_____
_____

Continued on back...



I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. 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 or 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.

Client Signature _____ Date _____

Practitioner Signature _____ Date _____