

PERSONAL INFORMATION

First Name: _____ Middle: _____ Last: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell: _____ Birth Date: _____

Occupation: _____ Employer: _____

Email Address: _____ Referred by: _____

Emergency contact: _____ Relation: _____ Phone: _____

CANCELLATION & LATE POLICY

24 hours advance notice is required for all cancellations and changes to appointments. Clients who do not show or do not give 24 hours notice will be charged for that session. Clients arriving late will receive their remaining scheduled time only, so that the next client's appointment will not be disrupted. Arriving 5 minutes early will help you relax and fully enjoy your session. Please let Davida know if you have any questions or concerns regarding this policy. These guidelines are in place to protect the valuable time of both the therapist and client.

MESSAGE HISTORY/TREATMENT INFORMATION

1. First Professional Massage? Y / N Date of last massage: _____

2. What are your primary reasons for receiving massage therapy? _____

3. List accidents, injuries, and surgeries – dates and treatment received: _____

4. Do you have chronic, ongoing pain? Y / N If yes, please describe: _____

5. Are you under a doctor, chiropractor, or other health practitioner's care? Y / N _____

6. Please list all medications including aspirin and ibuprofen: _____

7. Please list all known allergies: _____

8. Exercise: _____ times a week. Activities: _____

9. Do you sleep primarily on your back, side, or stomach? (please circle)

10. Do you smoke? Y / N How many cups of coffee do you drink a day? _____

Please check all that apply to you:

_____ Chronic pain in: ___Foot ___Leg ___Hip ___Low Back ___Mid Back ___Upper Back
 ___Neck ___Jaw ___Shoulder ___Arm ___Wrist/Hand

_____ On Computer: _____ hours a day

- | | | |
|-----------------------------|------------------------------|-----------------------------|
| _____ High Blood Pressure | _____ Arthritis | _____ Chronic Headaches |
| _____ Low Blood Pressure | _____ Osteoporosis | _____ Seizures |
| _____ Varicose Veins | _____ Gout | _____ High Stress |
| _____ Hemophilia | _____ Fibromyalgia | _____ Grieving |
| _____ Blood Clots/Phlebitis | _____ Bursitis | _____ Stroke |
| _____ Hypothyroidism | _____ Plantar Fasciitis | _____ Multiple Sclerosis |
| _____ Tumors/Cysts | _____ Scoliosis | _____ Anxiety/Panic Attacks |
| _____ Cancer | _____ TMJD | _____ Bipolar Syndrome |
| _____ Lymphedema | _____ Whiplash | _____ Insomnia |
| _____ Skin Infection: _____ | _____ Carpal Tunnel Syndrome | _____ Ulcers |
| _____ Easily Irritated Skin | _____ Internal pins, plates | _____ IBS |
| _____ Diabetes | _____ Pregnant | _____ Constipation |
| _____ Pneumonia | _____ PMS | _____ Diarrhea |
| _____ HIV/AIDS | Other: _____ | |
| _____ Lupus | _____ | |

I confirm that the above information is complete and correct and that I will update my massage therapist of any changes to my health status. It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind, which includes stress reduction, relief from muscular tension, spasm, pain, and/or increasing circulation and range of motion. I agree to communicate with my therapist anytime I feel like my well-being is compromised. I understand that massage therapists do not diagnose illness or disease, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

SIGNATURE: _____ DATE: _____

If client is under the age of 18, the consent of the parent or legal guardian is required.