Confidential Information

We want to make your appointment as pleasant and comfortable as possible. If at any time you have any questions regarding your visit, please let us know.

Name_____

Address_____City_____State____Zip_____

Home#_____ Cell#_____

Date of Birth_____E-Mail Address_____

Please Read the Following and Sign Below:

I understand that:
-This massage is not a replacement for medical care & that no diagnosis will be made.
-I will receive a massage that utilizes therapeutic treatment.
-Draping will be used during this session.
-Private areas including, but not limited to breast tissue will not be massaged.
-If I am uncomfortable for any reason, I can request the Therapist to make adjustments. If still not comfortable, upon Request the session will end. I will be responsible for the cost Of the portion of the massage that I received.

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Client Signature Therapist Signature Date

Name:_____ **DOB:**_____

How did you hear about us?_____

Have you ever received a massage before? Yes___No___Type_____

Are you taking medication?_____Describe_____

Have you consumed alcohol in the past 24 hours?_____

Are you currently pregnant?_____If yes…how many weeks_____

Occupation_____

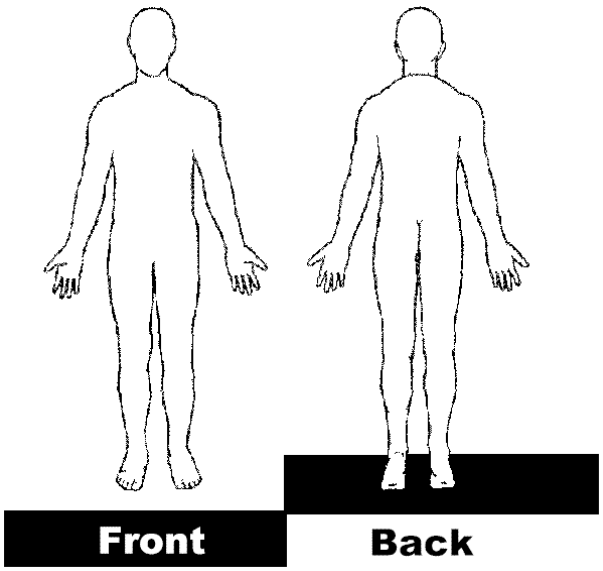
Have you had…?
When?

___Accident _____
___Surgery _____
___Heart Attack_____
___Whiplash _____
___Cancer _____

Do you have a history of the following?

__abdominal pain
___allergies to oils/perfumes
___arthritis/bursitis/gout
___back(upper)
___back(mid)
___back(lower)
___breast enhancement
___Broken bones
___colitis
___Decreased range of motion
___Diabetes
___Disk problems
___Pace Maker
__headaches
__high pressure
__joint ache
__neck pain
__nervous tension
__seizures
__sprains
__strokes
__varicose veins
__wear contacts or other prosthesis

Please mark an [X] below to indicate areas of pain:



Notes (for therapist use only):

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