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| **Personal Information**Name: Date of Birth: Address: Street City, State, ZipPhone number: Do You text? (y/n) Email: Okay to send appointment reminders? (y/n)*Emergency Contac*t: Name: Phone number: Relationship to you:**The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge**. 1. What are your top health priorities or concerns: (Physical, Emotional, Spiritual, Health & Wellness) (Why are you seeking Massage & Holistic Practices?)
2. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? (y/n) (If yes, please identify)
3. Do you have any particular goals in mind for this massage session? (y/n)
4. What is your previous massage experience? (If yes, how often?)
5. Do you prefer light, medium, or deep touch? (Circle)

 1. Are there areas that are more sensitive to touch? (y/n) (If, yes, where?)
2. Are there any parts of your body you do NOT want massaged? (Face, Feet, Neck, Abdominal Region, Upper Chest, etc.) (y/n)

 1. Is there any physical or emotional trauma that you want me to be aware of? (y/n)

(If yes, what would you like me to know? PTSD, Sexual or Physical Abuse)1. Do you experience stress in your work, family, or other aspect of your life? (y/n)

(If yes, how do you think it has affected your health?) muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other1. Do you have any difficulty lying on your front, back, or side? (y/n)

(If yes, please explain)1. Do you have any **Allergies** to oils, lotions or ointments**?** (y/n) (If yes, please list)

**Medical History****In order to plan a massage session that is safe and effective, I need some general information about your medical history.**1. Are you currently being monitored by your Primary Physician? (y/n) (If Yes, please explain)
2. Are you currently taking any Medications? (y/n) (If yes, please list medicine and the reason/s)
3. Have you been in an accident or suffered any injuries in the past? (y/n) (If Yes, please explain)
4. Have you had any surgeries in the past? (y/n) (If yes, please list dates and type of surgery:)

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| 1. Please check any condition listed below that applies to you:

 Acute Infection or Inflammation Arthritis                                                                              Joint / Bone Conditions or Problems  Muscle Sprain /Ligament -Tendon Strain  Bleeding Disorders / Easily bruised                                                     Cancer                                                                         Cardiac Issues Phlebitis/ Varicose Veins / DVT- Blood Clots                                                                          Circulatory Problems                                              DiabetesDizziness                                                                                                                                  Edema/SwellingHeadaches / Migraines                                                                      High/Low Blood Pressure                                             HIV/AIDS/other types of Infectious Diseases  Anxiety / Depression                                                          Kidney / Liver / Stomach / Bowel Disorders Metal Hardware/Braces/Pins/Screws/PlatesNumbness / TinglingNeurological Disorders  Respiratory Conditions / ProblemsIf female, Pregnant  Seizures/Epilepsy                    Skin Conditions Wear contacts / glassesWound |  | **Please check/circle if any of the following conditions apply:** Abdominal Pain Allergies (foods, medications, nuts, etc.)                          Arthritis                                                                              Anxiety / Depression                                                           Back / Neck pain or injuries Bleeding / Easily bruised                                                     Bursitis      Cancer                                                                         Cardiac Issues                                                                                 Circulatory Problems                                                                     Connective Tissue DisordersDetoxification from Alcohol / Drugs / Cigarettes                                                      DiabetesDizziness                                                                                                                                           Edema/Swelling Headaches  / Migraines                                                                     Hernia  High/Low Blood pressure                                             IV/AIDSImplants Insomnia / other Sleep disorders/difficulties |  Joint / Bone Conditions or Problems Kidney / Liver / Stomach / Bowel Disorders Metal Hardware / Braces / Pins / Screws / PlatesMuscle Strain / Sprain /PainNumbness / TinglingNeurological Disorders Paralysis  Phlebitis/Blood Clots  Respiratory Conditions / ProblemsIf female, Pregnant  Seizures/Epilepsy                    Sinus Problems  Skin Conditions  StressStrokeTobacco userTMJD Varicose Veins  Vertebral Disc Issues WhiplashWear contacts / glassesOther \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. Please explain any condition that you have marked above:

I, (print name) understand that the massage 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 therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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 that I am aware of. I understand that massage therapists 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 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 update my practitioner as to any changes in my medical profile and understand that there shall be no liability on the practitioner’s part should I forget to do so. It is also understood that any elicit 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. Clients Signature: Date: Theresa Sargent: Date:   |

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