THERAPY
{massage studio}

CLIENT INFORMATION & CONSENT FORM

NAME:	DATE OF BIRTH: / /
EMAIL:	HEIGHT: WEIGHT:
PHONE #:	(EMERGENCY CONTACT) NAME:
ADDRESS:	(EMERGENCY CONTACT) PHONE:
CITY: STATE: ZIP:	HOW DID YOU HEAR ABOUT THERAPY {MASSAGE STUDIO}?
OCCUPATION:	

PROBLEMS YOU HAVE OBSERVED: (**CHECK** IF OCCASIONAL, **CIRCLE** IF FREQUENT)

HEAD & NECK
- ☐ Headaches
- ☐ Neck pain/ tightness
- ☐ Lumps or swelling
- ☐ Migraines
- ☐ Wear glasses/ contacts
- ☐ Lasik (Date:_____)
- ☐ Other:_____

MUSCULOSKELETAL
- ☐ Aching muscles
- ☐ Fibromyalgia
- ☐ Aching joints
- ☐ Arthritis
- ☐ Low back pain
- ☐ Sciatica
- ☐ Shoulder pain L / R
- ☐ Thoracic Outlet Syndrome
- ☐ Spinal curvature
- ☐ Painful feet
- ☐ Painful wrists
- ☐ Carpal Tunnel
- ☐ TMJ disorder
- ☐ Broken Bones
- ☐ Sprain/ dislocation
- ☐ Other:_____

DIGESTIVE
- ☐ Bloated stomach
- ☐ Constipation
- ☐ Loose bowels
- ☐ Ulcer / Colitis
- ☐ Other:_____

CARDIOVASCULAR
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Swelling in feet
- ☐ Leg cramps
- ☐ Heart Disease
- ☐ Stroke/ CVA
- ☐ Stent/ Shunt
- ☐ Other:_____ _____

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ Easily out of breath
- ☐ Smoker
- ☐ Other:_____

REPRODUCTIVE/ URINARY
- ☐ Currently pregnant _____weeks
- ☐ High risk/ complicated pregnancy
- ☐ Lump or pain in breast
- ☐ Menopause
- ☐ Trying to get pregnant
- ☐ Other:_____

SKIN
- ☐ Bruise easily
- ☐ Varicose veins
- ☐ Skin allergies
- ☐ Tender areas
- ☐ Other:_____

NERVOUS SYSTEM:
- ☐ Difficulty relaxing
- ☐ Difficulty sleeping
- ☐ Tuberculosis
- ☐ Epilepsy
- ☐ Other:_____

OTHER
- ☐ Tumor/ Cancer Where: _____
- ☐ Diabetes

Please list any injuries, accidents or hospitalizations in the past 5 years: _____
_____
_____

Please list any medications, vitamins or supplements you are currently taking: _____
_____
_____

Is this your first massage? Y / N Are you currently participating in an exercise program? Y / N Do you currently see a chiropractor? Y / N

SIGNATURE REQUIRED ON NEXT PAGE

I, (print name) _____ understand that the massage I receive is provided for the basic purpose of relief of muscular tension, and relaxation. If I experience any pain or discomfort during my sessions, 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 skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of a 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 keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature:

Date:

Thank You!

SPACE BELOW FOR THERAPIST NOTES

General notes:_____
_____
_____
_____
_____

Date:	Session Notes: