Client Information

Name: _____ Telephone: ( ) _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Referred by: _____ Telephone: ( ) _____

In case of emergency: _____ Telephone: ( ) _____

General & Medical Information

Occupation: _____ Height: _____ Weight: _____ ☐ Male ☐ Female

Are you basically in good health? ☐ Yes ☐ No

Has there been any change to your health in the past year? ☐ Yes ☐ No

If so, please explain: _____

Physician: _____ Telephone: ( ) _____

If you answer "yes" to any of the following questions, please explain as clearly as possible.

Do you suffer from acne? ☐ Yes ☐ No

Do you have allergies? ☐ Yes ☐ No
Specify:

Do you have arthritis? ☐ Yes ☐ No

Do you have high blood pressure? ☐ Yes ☐ No
If yes, what medication are you taking?

Do you suffer from epilepsy or seizures? ☐ Yes ☐ No

Do you suffer from claustrophobia? ☐ Yes ☐ No

Do you have varicose veins or distended capillaries? ☐ Yes ☐ No

Do you have any contagious diseases? ☐ Yes ☐ No

Do you have heart disease? ☐ Yes ☐ No

Do you have diabetes? ☐ Yes ☐ No

Do you have asthma? ☐ Yes ☐ No

Have you ever had or are you being treated now for cancer? ☐ Yes ☐ No
Please explain:

Do you suffer from any blood disorder? ☐ Yes ☐ No

Do you have seborrhea? ☐ Yes ☐ No

Have you ever had surgery? ☐ Yes ☐ No
Please explain:

Are you pregnant or nursing? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Do you wear dentures? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

Are you currently being treated by a physician for any condition? ☐ Yes ☐ No
Please explain:

Do you have any other medical condition I should know about?

Are you taking any medications *(including non-prescription drugs)*

☐ Birth Control Pills ☐ Diuretics
☐ Accutane ☐ Vitamins/Supplements
☐ Hormone Therapy ☐ Antibiotics
☐ Aspirin/Ibuprofen/Acetaminophen
☐ Vitamin A (topical or internal)

Are you using any of the following products?

☐ Renova ☐ Benzoyl Peroxide
☐ Glycolic Acid ☐ Retin-A

How much water do you drink a day? _____ glasses

Do you exercise regularly? ☐ Yes ☐ No

How would you describe your overall level of stress?
☐ Low ☐ Medium ☐ High

Comments: _____

Please take a moment to carefully read the information you have provided and sign where indicated. If you have a specific medical condition or specific symptoms, certain esthetic treatments may be contraindicated. A referral from your primary care provider may be required prior to service being rendered.

Client Signature: _____ Date: _____

Disclaimer

___ I understand that the position of my massage therapist is **not** that of a medical doctor. **He/She does not diagnose, treat, or prescribe any supplements or pharmaceutical medications**. His/Her position is to help me relax my body through trained modalities in massage therapy to the best of his/her ability. I also understand that my massage therapist's massage and bodywork can not replace my medical doctors' treatments. **If I have any medical conditions I will inform my medical doctors and seek my medical doctors' approvals prior to my massage and bodywork sessions.**

___ I also understand that I might have mild discomfort in my body such as fatigue, light headaches, thirst, nausea or muscle soreness after the massage treatment, which is called a **healing crisis** due to toxins being disturbed and leaving the body. **I will drink a plenty of water, rest and take an Epsom salt bath to sooth the body if it is indicated and necessary. No alcohol should be consumed at least 2 hours before and after the massage session to avoid intoxication**.

___ I also understand that **bruising might occur occasionally after a deep tissue massage treatment due to smoking, medication side effects, hereditary conditions, etc..**

___ If I come in for **emotional release bodywork**, I understand that my massage therapist is making his/her best effort to open up my energy chakras and channels and assist me with healing. It is up to me to open up myself to trust my massage therapist's skills and expertise and heal my emotional scars. if I am not comfortable with my massage therapist's bodywork during the session, I will inform him/her and stop it right away.

___ If, after the treatment, I have any uncomfortable feelings besides those described above, I will inform my massage therapist right away **within a 24 hour period**. My massage therapist is **not** responsible for any body condition that may have been related to the massage treatment.

My massage therapist has informed me of the above information before the treatment.

Client signature _____ Date _____