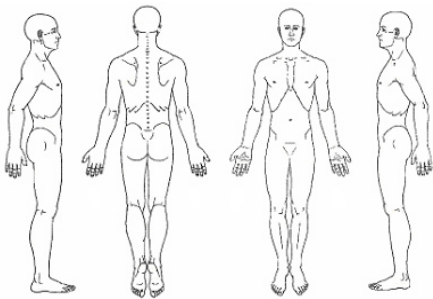


This questionnaire is confidential and will become part of your massage therapy records.

Name:		Preferred Pronoun:	DOB:
Address:			
Phone:		Occupation:	
Email:		Emergency Contact:	
Massage History: <input type="checkbox"/> This is my first professional massage <input type="checkbox"/> I have had professional massage in the past			
How did you hear about us:			
Thanks, but I'd prefer NOT getting emails about Special Offers for massage <input type="checkbox"/>			

AREAS OF TENSION OR CONCERN



Mark and describe areas of tension or concern:

INJURIES:

Describe Injury (onset, cause, symptoms, etc.)

What **alleviates** symptoms? (therapies or self care you are doing)

What **aggravates** symptoms? (specific activities or movements)

WHAT ARE YOUR GOALS FOR YOUR MASSAGE SESSION TODAY?

(i.e. Pain Management, Relaxation, Athletic Training Support)

PERSONAL HEALTH HISTORY

<input type="checkbox"/> Pregnant Due date: ____/____/____	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Muscle, Tendon or Ligament Injury	<input type="checkbox"/> Joint Disorder (Rheumatoid arthritis, osteoarthritis)	<input type="checkbox"/> Cancer
<input type="checkbox"/> Menstrual Pain (now OR in general)	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Circulatory Condition (i.e. atherosclerosis, thrombus/embolism, high or low blood pressure)
<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Skin Condition: (i.e. athlete's foot, warts, acne, sunburn)	<input type="checkbox"/> Inflammation
<input type="checkbox"/> TMJ or teeth grinding	<input type="checkbox"/> New scar tissue	<input type="checkbox"/> Fever
<input type="checkbox"/> Fatigue/Stress	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Flu
<input type="checkbox"/> Mental Health: (i.e. anxiety, depression)	<input type="checkbox"/> Hernia (i.e. vertebral discs, organs)	<input type="checkbox"/> OTHER

Please explain any condition marked above:

This questionnaire is confidential and will become part of your massage therapy records.

SCOPE OF MASSAGE AND CLIENT PARTICIPATION

Please take a moment to **read and initial** all of the following statements:

<input type="checkbox"/>	I affirm that I have notified my therapist of all known medical conditions and injuries.
<input type="checkbox"/>	I agree to inform the therapist of any changes in my health and medical condition.
<input type="checkbox"/>	I understand that the services offered today are not a substitute for medical care . I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.
<input type="checkbox"/>	I will immediately inform my therapist if I experience pain or discomfort during the session , so that pressure/strokes can be adjusted to my level comfort.
<input type="checkbox"/>	I should feel free to ask my therapist any questions before, during, or after the session. Your therapist is a trained professional and will be happy to make you feel informed and comfortable.
<input type="checkbox"/>	I should feel free to talk or be mostly silent for my massage session . My massage therapist will ask questions related to the massage, but otherwise being quiet or chatty is welcome.
<input type="checkbox"/>	I understand that for a therapeutic massage I will be either completely undressed or can leave my underwear on . A sheet will cover me for the duration of the massage session, and only the areas being worked on will be exposed.
<input type="checkbox"/>	Prior to my massage, I will remove all jewelry and pull any long hair back with a clip or band.
<input type="checkbox"/>	I understand that if I am late to a session , I can expect that the massage will end at the originally scheduled time and I will be charged for the full session.

I have read, understand, and agree to all above statements. I understand that massage is provided for the basic purpose of relaxation and relief of muscular tension. Therapeutic massage is not a substitute for medical care. Under certain medical conditions, massage should not be performed, and as such I have stated all my known medical conditions and answered questions honestly. I agree to update my massage therapist of any changes related to my health and medical conditions, and understand that there will be no liability on the therapist's part should I fail to do so.

Client name: _____

Client signature: _____

Date: _____

Therapist signature: _____

Therapist Notes: