License # ME1747

Name: ____ Date: __________ Gender: __ ________ __

CONTACT INFORMATION:

Phone (H): ______________________(CELL): ________________ (Cell Carrier) ______________

Email: ____ Birth Date: _______________

Address: ______________________________ City: _____________ State: ____ Zip: _______________

Emergency Contact & Phone: ____

Primary Reason for Massage (*manages pain, relieves discomfort, maintains health, reduces stress, simply relax, etc.*): ____

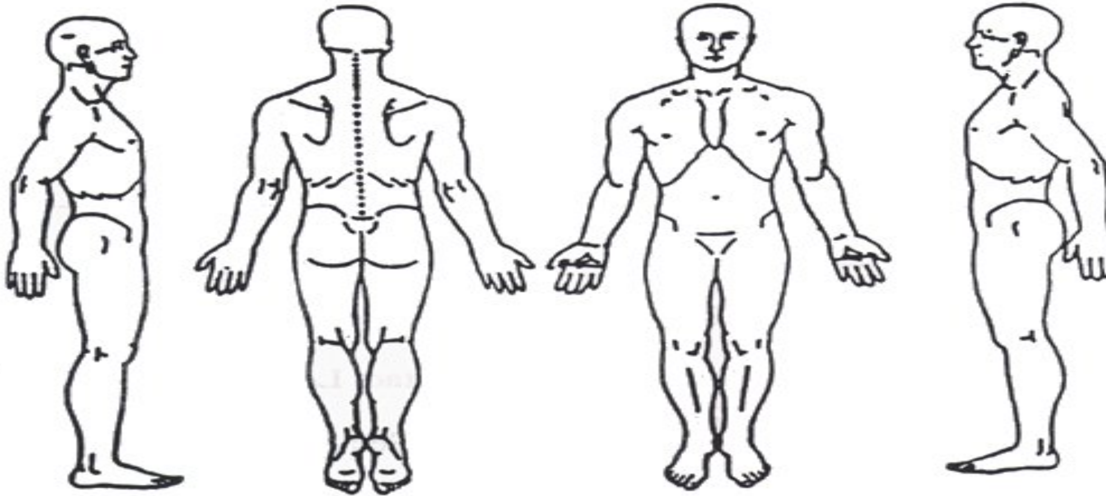
Have you ever had a professional massage before? Yes / No how recently? _________________ __

How did you hear about us? ____

Please check all that apply:

Yes No Do you frequently suffer from stress?
Yes No Do you have diabetes?
Yes No Do you experience frequent headaches?
Yes No Are you pregnant? What trimester? __________
Yes No Do you suffer from arthritis?
Yes No Are you wearing contact lenses?
Yes No Do you have high blood pressure?
Yes No Do you suffer from epilepsy or seizures?
Yes No Do you suffer from joint swelling?
Yes No Do you have varicose veins?
Yes No Do you have osteoporosis?
Yes No Do you have any allergies, specifically topical? Please List: ______________________________
Yes No Do you bruise easily?
Yes No Have you had any broken bones in the past two years?
Yes No Have you been in an accident or suffered any injuries in the past two years?
Yes No Do you have tension or soreness in a specific area?
Please specify: ____
____
Yes No Do you have cardiac or circulatory problems?
Yes No Do you suffer from back pain?
Yes No Do you have numbness or stabbing pains anywhere?
Yes No Are you very sensitive to touch or pressure in any area?
Yes No Do you have any other medical condition your therapist should know about?
Comments: ____
Yes No Have you had any recent surgeries that the therapist should know about?
Comments: ____
Yes No Are you taking any medications your therapist should know about?
Comments:
____

Please mark any areas of special attention, tension, sensitivity, or pain on the diagram:
O= Pay Special Attention To: X= Pain A= Avoid L= Ticklish T= Tension S= Sensitivity



- Techniques to be used may include Swedish, Deep Tissue, Trigger Point, Reflexology, Joint Range of motion techniques and stretches
- Body parts to be massages include the face, neck, shoulders, back, arms, buttocks, hip flexors, legs (front and back), pectorals, abdominals, ribs, and feet.
- The massage therapist WILL NOT engage in breast massage***. Genitals are always EXCLUDED***.
- Standard draping will be used; meaning only the body part being massaged will be exposed.

I understand that the massage therapist does not prescribe medical treatment or pharmaceuticals, or nor does he/she perform any spinal adjustments. Massage therapy is not a substitute for medical examinations and diagnosis. It is recommended that I see a physician for any physical ailment that I might have. I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorders. Any sexual misconduct exhibited by the client will result in immediate termination of the session, and the client will be liable for payment of the scheduled appointment.

If I cancel, reschedule, or NO SHOW an appointment without 24 hour notice, I agree to PAY FOR THE FULL SESSION, also you lose the rebook discount for the next session and any gift certificates will be forfeited. Services totaling over 2 hours must be prepaid and must give a 48hr notice.

If for any reason the client is uncomfortable, the client may ask the therapist to cease the massage and the therapist will end the session.

I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health. All the information provided above is, to the best of my knowledge, correct and current.

Signature: ____ Date: ______________________

Therapist Signature: ______________________________________ Date: ______________________

Consent to Treatment of Minor: By my signature below, I hereby authorize **Every Body Massage Therapy** to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian: ____ Date: ______________________________

CONFIDENTIAL INFORMATION