Confidential Client Health Information

Name: _____ Birthdate: _____

Address: _____ City: _____ State/Zip: _____

Phone: _____ Email: _____

Occupation: _____ Referred by: _____

Emergency contact: _____ Phone: _____

Do you have a doctor referral / prescription? Yes ☐ No ☐ ** A prescription saves you 8%*

** If you are seeking insurance reimbursement, please let me know and I will provide a receipt and session notes for you to submit.*

Massage Information

How do you feel today?

Have you received professional bodywork before? Yes ☐ No ☐ How recently?

What are your goals/expected outcomes for receiving bodywork?

Describe your typical day. Please include work ergonomics, activities, hobbies, etc:

Please indicate conditions that pertain to you:

___ Allergies
___ Anxiety
___ Arthritis
___ Bruise easily
___ Cancer
___ Depression
___ Diabetes
___ Dizziness
___ Digestive Condition
___ Endocrine or Thyroid
___ Epilepsy
___ Fatigue
___ Fibromyalgia
___ Headaches
___ Heart Condition
___ High/Low Blood Pressure
___ Infectious Diseases
___ Memory Loss, Confusion
___ Muscle Spasm
___ Numbness/Tingling
___ Osteoporosis
___ Skin Condition
___ Stroke
___ Swelling
___ TMJ, Clenching
___ Varicose Veins
___ Whiplash

How do these conditions affect your activities of daily living (i.e sleep, exercise, work, childcare)?

Please list any surgeries or serious injuries including the year:

Please list current medications / supplements, including over the counter:

Are you wearing contacts? Yes ☐ No ☐ Are you wearing dentures? Yes ☐ No ☐

Are you wearing a hairpiece? Yes ☐ No ☐ Are you pregnant? Yes ☐ No ☐

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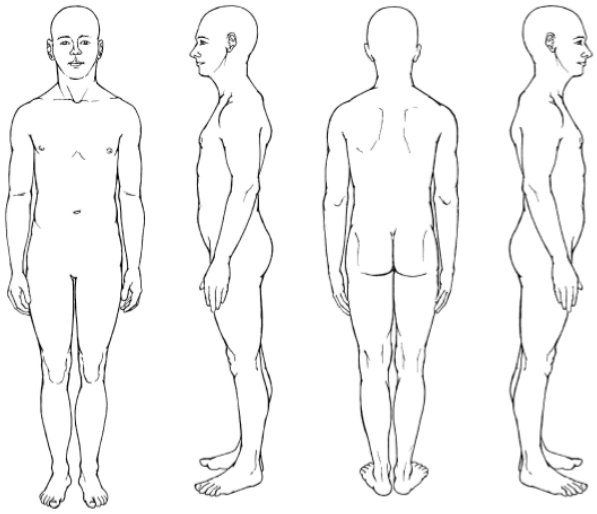
BODY MAP

Please indicate with an **X** any areas that you feel need the most attention:



Are there any areas that you DO NOT want massaged?

IMPORTANT- I use essential oils both topically and aromatically throughout the bodywork session. Please list any known food, oil, herb, plant, or flower sensitivities. Are there are any scents that you simply don't care for?

Is there anything I did not ask about your current health or health history that I should be aware of?

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform DeAnna, my massage therapist, so that adjustments may be made to my level of comfort. I understand massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and I should see a qualified medical specialist for any mental or physical ailment of which I am aware. Massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and nothing said in the course of the session given should be construed as such. Because massage/bodywork 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 DeAnna updated as to any changes in my medical profile, and understand that there shall be no liability on her part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made will result in immediate termination of the session, and I will be liable for payment of the full appointment.

CANCELLATION POLICY: Failure to provide 24 hours notice of cancellation will result in a full charge of agreed upon services.

Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____

DeAnna Creighton, LMT: _____