**Client Information**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of birth:\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact (name and number):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Check any of the following that apply to you (include pain level 1 mild-10 severe):

Stress\_\_\_\_ Difficulty walking\_\_\_\_

Neck pain\_\_\_\_ Difficulty sitting\_\_\_\_

Upper back Pain\_\_\_\_ Difficulty standing\_\_\_\_

Lower back pain\_\_\_\_ Hip pain\_\_\_\_

Joint pain\_\_\_\_ (knee, ankle, elbow, wrist) Headaches\_\_\_\_

Is pain acute (within a few days) or chronic (longer than a month)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any activity that makes condition worse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List any recent injuries:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List medications taken regularly:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List any surgeries with date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Informed Consent Form**

Do you have any of the following conditions? If yes, please explain below.

Diabetes\_\_\_\_ Cancer\_\_\_\_

Pregnant\_\_\_\_ Epilepsy or seizures\_\_\_\_

Arthritis\_\_\_\_ Varicose veins\_\_\_\_

Osteoporosis\_\_\_\_ Contagious disease\_\_\_\_

Numbness or stabbing pain\_\_\_\_ Cardiac or circulatory problems\_\_\_\_

High blood pressure\_\_\_\_ Bruise easily\_\_\_\_

Allergies\_\_\_\_ Depression\_\_\_\_

Sensitivity to touch or pressure\_\_\_\_ Any mental disorders\_\_\_\_

Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I understand that massage should not be construed as a substitute for a medical examination, diagnosis, or treatment. 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 the 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 massage therapist updated as to any changes in my medical profile before the beginning of the session and understand that there shall be no liability on the part of the massage therapists should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances toward massage therapist will result in immediate termination of the session. I also understand that the massage therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated. I understand that the massage I receive is provided for the basic purpose of relaxation, improved range of motion and circulation, and relief of muscular pain and tension. Pain during the session may be experienced, if the pain level rises above 7 (on a 1-10 scale), I will immediately inform the therapist so that the pressure and /or strokes may be adjusted to my level of comfort.

Client signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_