Client Information and Health History

Welcome to Free Spirit Massage. Please complete the following form. The information provided is confidential and will assist your LMT with providing a safe and client centered massage.

Name_____ D.O.B._____/_____/_____ Referred by _____

Address_____ City_____ State_____ Zip_____

Email Address_____ Preferred Phone (_____)_____

Occupation_____ Emergency Contact_____ Phone (_____)_____

Physician_____ Phone(_____)_____

Do you consent to receiving appointment reminders via text message? ◇Yes ◇No Cell (_____)_____

Have you had a professional massage before? ◇ Yes ◇ No If yes, how recent?_____

What kind of pressure do you prefer? ◇ Light ◇ Medium ◇ Firm

What are your goals/concerns for today's session?_____

Please state any recent or past injuries or medical treatments_____

_____

Please list any allergies (seasonal or other) _____

Do you experience difficulty lying on your ◇ Front ◇ Back ◇ Side

Are you under medical care or supervision now? ◇ Yes ◇ No If yes, for what?_____

_____

Are you currently taking any medications? ◇ Yes ◇ No If yes, what medications?_____

_____

Please check the following that apply or have applied to you:

◇Arthritis	◇Back Pain	◇Blood Clots	◇Broken Bones
◇Bursitis	◇Cancer	◇Chest Pain	◇Cold Feet/Hands
◇Constipation	◇Diabetes	◇Diarrhea	◇Edema
◇Fainting Spells	◇Fibromyalgia	◇Headaches	◇Heart Condition
◇Herniated Disc	◇High Blood Pressure	◇Low Blood Pressure	◇Menstrual Pain/PMS
◇Neck Pain	◇Numbness Feet/Hands	◇Severe Depression	◇Shortness of Breath
◇Sinusitis	◇Skin Disorder	◇Stomach Disorder	◇Tinnitus
◇Varicose Veins	◇Other_____		

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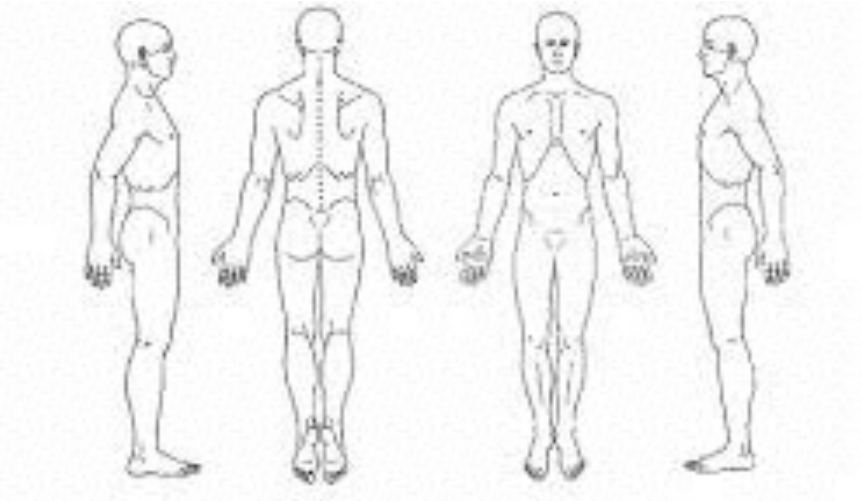
Please indicate location(s) of sore or painful areas on the diagram below.



Consent for Treatment

If I experience any pain or discomfort during this session, I will inform the practitioner so that the pressure/treatment may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or 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/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 the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care (ABMP).

Client Signature_____ Date_____

Parent of Guardian Signature_____ Date_____

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