Client Information

Name: _____ Phone: _____

Address: _____

Email: _____ DOB: _____

In Case of Emergency: _____ Phone: _____

Occupation: _____ Male ☐ Female ☐ Physician: _____

Health Insurance Carrier: _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition, specific symptoms, or difficulties, please let us know; massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? ☐ No ☐ Yes If so, How Recent? _____

What are your massage/bodywork goals? _____

What kind of pressure do you prefer? ☐ Light ☐ Medium ☐ Firm Do you like heat? ☐ No Heat ☐ Warm ☐ Very Warm

Is there anything specific you would like to share with me about problem areas, your health, or ailments? _____

_____

_____

If you answer "yes" to any of the following questions, please explain as clearly as possible.

☐ 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?
☐ Yes ☐ No Do you suffer from arthritis?
☐ Yes ☐ No Are you wearing contact lenses?
☐ Yes ☐ No Are you wearing dentures?
☐ Yes ☐ No Do you have high blood pressure?
☐ Yes ☐ No Are you taking high blood pressure medication?
☐ 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 any contagious diseases?
☐ Yes ☐ No Do you have osteoporosis?
☐ Yes ☐ No Do you have any allergies?

☐ Yes ☐ No Do you bruise easily?
☐ Yes ☐ No Any broken bones in the past 2 years?
☐ Yes ☐ No Any injuries in the past 2 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?
☐ Yes ☐ No Are you sensitive to touch or pressure in any areas?
☐ Yes ☐ No Have you ever had surgery? Explain below.
☐ Yes ☐ No Please list any other medical condition or medication I should know about:

Comments: _____
_____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes 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 have 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 practitioners part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made my me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

Consent to Treatment of Minor: By signing below, I hereby authorize Melody John to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Parent or Guardian Signature: _____ Date: _____