

# Client Information

Name \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail: \_\_\_\_\_

Referred by: \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

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 or specific symptoms, 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?  Yes  No How recently? \_\_\_\_\_

What are your massage or bodywork goals? \_\_\_\_\_

What kind of pressure do you prefer?  light  medium  firm

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

- |   |   |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you frequently suffer from stress?          | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you bruise easily?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have diabetes?                          | <input type="checkbox"/> Yes <input type="checkbox"/> No Any broken bones in the past two years?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you experience frequent headaches?          | <input type="checkbox"/> Yes <input type="checkbox"/> No Any injuries in the past two years?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant?                              | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have tension or soreness in a specific area?<br>Please specify _____        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from arthritis?                  |   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing contact lenses?                |   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing dentures?                      | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have cardiac or circulatory problems?                                       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have high blood pressure?               | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from back pain?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you taking high blood pressure medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have numbness or stabbing pains?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from epilepsy or seizures?       | <input type="checkbox"/> Yes <input type="checkbox"/> No Are you sensitive to touch or pressure in any area?                                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from joint swelling?             | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had surgery? Explain below.  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have varicose veins?                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Other medical condition, or are you taking any<br>medications I should know about? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any contagious diseases?           |   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have osteoporosis?                      | Comments _____  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any allergies?                     | _____   |

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 or 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.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Practitioner Signature \_\_\_\_\_ Date \_\_\_\_\_

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

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

I, \_\_\_\_\_, give my permission for Trina T. Brown to leave any information for me, use her name and mention her massage therapy practice at the following (please check all that apply):

- Home Phone \_\_\_\_\_
- Work Phone \_\_\_\_\_
- Cell Phone \_\_\_\_\_
- Fax \_\_\_\_\_
- Mailing address From other side of this form
- Email address From other side of this form
- Other: (please specify) \_\_\_\_\_

I would like to be added to Trina T. Brown's mailing list so I may receive her massage therapy and bodywork newsletter, Body Sense Magazine, and news about her practice.  Yes  No

I would like to receive communications from Trina T. Brown at my email address, provided on the other side of this form.  Yes  No

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

Authorized Staff Person: Trina T. Brown