

Finding Balance Massage Therapy
Client Information

Name _____ Phone _____ DOB _____

Address _____ City _____ State _____ Zip _____

Email _____ Occupation _____ Male Female

Emergency Contact _____ Phone _____

How did you hear about us? _____

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 may be contraindicated. A referral from your doctor may be required prior to service being provided.

Have you ever experienced a professional massage session? Yes No How recently? _____

What are your massage goals? _____

What kind of pressure do you prefer? Light Moderate Firm

If you answer "yes" to any of the following questions, please explain as clearly as possible.
Feel free to use the back of this form if necessary.

Do you have any contagious diseases? Yes No _____

Do you have osteoporosis? Yes No _____

Do you bruise easily? Yes No _____

Any broken bones or injuries in the past two years? Yes No _____

Do you have cardiac or circulatory problems? Yes No _____

Do you suffer from back pain? Yes No _____

Do you have any numbness or stabbing pains? Yes No _____

Do you have tension or soreness in a specific area? Yes No _____

Are you sensitive to touch or pressure in any area? Yes No _____

Have you ever had surgery? Yes No _____

Do you have diabetes? Yes No _____

Do you experience frequent headaches? Yes No _____

Are you pregnant or trying to become pregnant? Yes No _____

Do you suffer from arthritis? Yes No _____

Do you have high blood pressure? Yes No If yes, are you taking medication for it? _____

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 other medical condition or are you taking any medications I should know about? Yes No

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the 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 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 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 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. I have received and read a copy of the policies of Finding Balance Massage Therapy.

Client Signature _____ Date _____