Do you have any skin disorders or allergies (i.e. latex)? N Y – please explain:______________

____

Do you regularly drink caffeine beverages (coffee, tea, sodas, etc.) N Y – frequency______________

Do you smoke? N Y – how much?______________

Are you pregnant? N Y – estimated due date?______________

Are you participating in a regular fitness program? N Y – please describe:______________

____

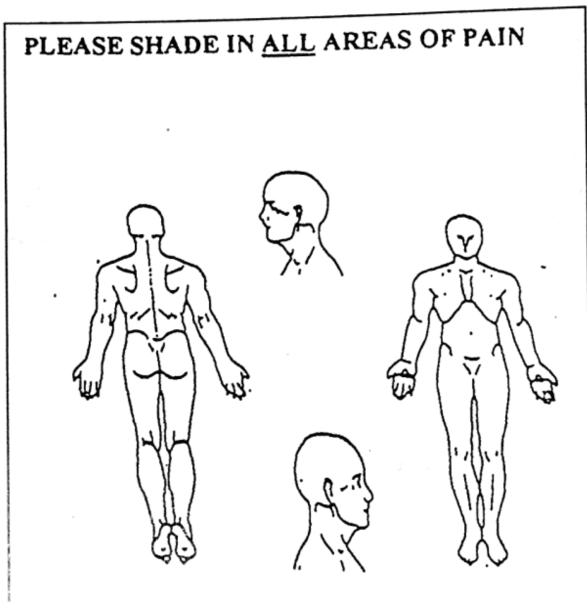
Do you have any other medical condition or physical limitation that I need to know before you receive this bodywork?

N Y – please explain:______________

Please circle any of the following that apply, present or past:

AIDS (or HIV related
Abdominal hernia
Hiatal Hernia
Acid Reflux
Stomach Disorders
Constipation
Diarrhea
Arthritis
Bursitis
Diabetes
Cancer
Shortness of Breath
Chest Pain
Heart Conditions
Low Blood Pressure
High Blood Pressure
Varicose Veins
Blood Clots
Dizziness
Loss of balance
Fainting Spells
Ears Ring
Edema

Severe Irritability
Severe Depression
Severe Menstrual Pain
PMS
Fatigue
Broken Bones
Herniated Disc
Headaches
Sinusitis
TMJ
Neck Pain
Back Pain
Sciatic Pain
Knee Pain
Feet Cold
Foot Numbness
Foot Pain
Shoulder Pain
Arm / Elbow Pain
Carpal Tunnel
Hand Numbness
Hands Cold
Scoliosis



I have listed ALL my known medical conditions, physical limitations, and medications. **I will inform my therapist of any changes in my physical health or medications.** I understand that a licensed massage therapist does not diagnose illness, disease, or any other medical, physical or psychological disorder, nor performs any spinal manipulations. I am responsible for consulting a qualified physician for any problems that I have.

I agree to pay for all services at the time they are rendered, unless prior arrangements have been made.

CANCELLATIONS and MISSED APPOINTMENTS: Unless you are ill or have an emergency, we require 24 hr. notice for any schedule changes, or you may be responsible for the full session fee. We cannot do bodywork sessions if you are sick. If there is a question, please call.

I understand the information contained herein is privileged and confidential. I authorize the release of any information pertaining to my health to my attorney, insurance company, or referring physician / therapist.

INSURANCE COVERAGE: Our prescription form completed by your physician must be on file prior to treatment. I will give you the forms to file to your insurance company after payment has been made.

Signature:______________________________ Date:______________

If client is a minor, signature of parent/guardian:

If client is a minor, signature of parent/guardian:____