Client Information

Name: ______________________ Date: ______________
Address: ______________________ Home Phone: ______________
City: ________State: ______Zip: ________ Cell Phone: ______________
Occupation: ______________________ Work Phone: ______________
Date of Birth: ______________________ Email: ______________
Referred by: ______________________
Emergency Contact: ______________________ E.C. Phone: ______________

Health / Medical History

Are you experiencing any of the following:

___ Cold/Flu
___ Fever
___ Infections
___ Contagious Conditions
___ Burns/Sunburn
___ Skin Condtions (e.g. warts)
___ Cuts/Bruises
___ Numbness/Tingling
___ Piercing or Stabbing Pain
___ Frequent Headaches
___ Back Pain
___ Arthritis
___ Joint Swelling
___Tendonitis
___ Depression/Anxiety
___ Muscular/Skeletal Disorders
___ New tattoos/piercings
___ Digestive Disorders
___ Possible or Definite Pregnancy
___ Other ______________

Have you ever been diagnosed with, or been advised to seek treatment for any of the following:

___ High / Low Blood Pressure
___ Stroke / TIAs
___ Diabetes / Low Blood Sugar
___ Heart Disease
___ Aneurysm
___ Anemias / Blood Disorders
___ Blood Clots / Phlebitis
___ Other Circulatory Conditions
___ Varicose veins
___ Bruising easily
___ Lymphatic Conditions
___ Kidney / Bladder Conditions
___ Liver / Gall Bladder Conditions
___ Cancer
___ Reproductive System Conditions
___ Allergies
___ Osteoporosis
___ Disc Disorders
___ Neuritis / Nerve Disorders
___ Seizure Disorders / Epilepsy
___ Asthma
___ Chronic Respiratory Conditions
___ Chronic Sinus Conditions

Are you currently:

Taking any prescribed medications? Yes No ______________________________
____

Taking any over the counter medicines, supplements, herbs, etc.? Yes No ______________________________
____

Using any prosthetics? (including contacts & dentures) Yes No ______________________________

Have you ever had any:

Hospitalizations/Surgeries Yes No ______________________________
____

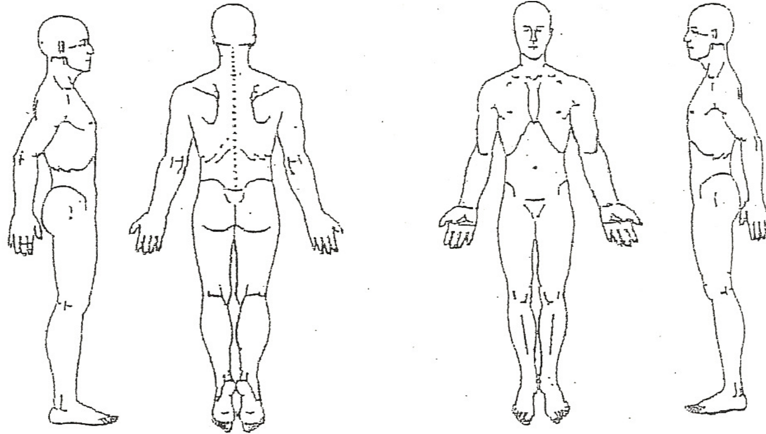
Accidents/Injuries Yes No ______________________________
____

Broken/Dislocated Bones Yes No ______________________________
____

Have you ever experienced professional massage or bodywork? Yes No How recently? ______________________

Massage Therapist Use Only:
____
____
____
____
____

Please describe how you are feeling today, and note any places of tension, pain, discomfort, etc. on the diagram below:



Comments:
____
____
____

Waiver and Release

I, ____, understand that massage is provided for the basic purpose of relaxation, stress reduction 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.

Massage services are not meant to take the place of a physician's care. Information exchanged during a massage is educational in nature, not diagnostic or prescriptive, and is to be used at my own discretion. Because massage should not be performed relative to certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I understand that it is my responsibility to keep the massage therapist updated as to any changes in my medical profile.

I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session.

I hereby waive and release my massage therapist, Centre Ave. Massage & Spa and anyone affiliated with it, from any and all liability, past, present and future, relating to massage therapy and body work.

Signature: ____ Date: ________________________________

If client is a minor (under 18 years of age):

By my signature below, I hereby authorize Centre Ave. Massage & Spa to administer massage/bodywork, or somatic therapy techniques to my child or dependent, ____, as they deem necessary.

Signature of Parent or Guardian ____ Date ______________________