Client Information

Name_____ Birthday_____

Address_____ Telephone_____

City_____ State_____ Zip_____

Email_____

Occupation_____ For how long? _____

Referred By? _____

Please take a moment to carefully read the following questions. Explain where needed.

Have you ever experienced a professional massage?	☐ Yes	☐ No
Do you have tension or soreness in an area? Where?	☐ Yes	☐ No
Do you frequently suffer from stress?	☐ Yes	☐ No
Do you have frequent headaches or migraines?	☐ Yes	☐ No
Do you have any inflammation or arthritis? Where?	☐ Yes	☐ No
Do you have any allergies?	☐ Yes	☐ No
Do you have varicose veins or phlebitis?	☐ Yes	☐ No
Do you have high blood pressure?	☐ Yes	☐ No
Do you have osteoporosis or bruise easily?	☐ Yes	☐ No
Do you suffer from pain, numbness, or tingling sensations? Where?	☐ Yes	☐ No
Do you have any contagious diseases?	☐ Yes	☐ No
Do you have any metal plates or pins?	☐ Yes	☐ No
Do you have any cardiac/circulatory problems? If so, explain.	☐ Yes	☐ No
Are you currently pregnant? If so, how far?	☐ Yes	☐ No
Do you have any other medical conditions that I should be aware of?	☐ Yes	☐ No

Please explain:

If I experience any pain or discomfort during this session, I will immediately inform the massage therapist so that the pressure may be adjusted to my level of comfort. I affirm that I have stated all known medical conditions, and have answered all questions honestly. I agree to keep the massage therapist updated to any changes in my medical profile and understand that there shall be no liability on the therapist's part.

Client Signature_____ **Date**_____

Practitioner Signature_____ **Date**_____

Consent to Treatment of Minor: By my signature below, I hereby authorize Sarah C. Bellman, LMT to administer massage therapy to my child or dependent.

Signature of Parent/Guardian_____ Date_____