INTENTIONAL WELLNESS AND MASSAGE

Name:_____ Phone_____ Email_____

Address_____ City_____ State ___ Zip_____

Date of Birth_____ Occupation _____

Have you ever had massage therapy? YES NO Preference for pressure? _____

Are you currently taking medications? YES NO If so please list name and reason:_____

Are you currently seeing a healthcare professional? YES NO

Reason/Treatment?_____

Please check if any of the following apply- include additional info if needed

__Arthritis
__Diabetes
__Blood clots
__Broken/dislocated bones
__Bruise easily
__Cancer
__Hepatitis (A,B,C)
__Contagious skin conditions
__Stroke
__Surgery
__Varicose Veins
__Headaches
__Back Problems
__High Blood Pressure
__Insomnia
__Muscle Strain
__Pregnancy
__Scoliosis
__Whiplash
__TMJ syndrome

Additional Information_____
_____

Current Sensitivities? Skin rash___ Open Cuts___ Severe Pain___ Injuries/Bruises___ Cold/Flu__ Other_____

Fragrance or Skin Product Allergies?_____

What are you goals for this session?_____

*The following are normal responses to massage/relaxation. Trust your body to do what it needs: sighing/yawning/change in breathing, need to move or change position, skeletal adjustments, emotional feelings/expressions, gaseousness, energy shifts, falling asleep.

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and can reduce muscular tension; it is not a substitute for medical examination, diagnosis and/or treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for full payment.
3. I am aware that if I need to reschedule my appointment, I must do so 24 hours in advance or I may be liable for full payment.

Signature: _____Date:_____