Body | Mind & Spirit
MASSAGE THERAPY

CLIENT INFORMATION & RELEASE FORM

Name _____ Date: _____

Address _____

City/State/Zipcode _____

Home # _____ Work # _____ Cell# _____

E-Mail _____

Birthdate _____ Male _____ Female _____ Martial Status _____

Occupation _____ Referred by _____

***To ensure the best results from you session, please answer the following questions*.**

Any allergies to topical agents? Yes _____ No _____

Are you currently under treatment for any medical conditions? No _____
Yes, please explain _____

Are you taking medication? If so, please list _____

Have you had a professional massage before? Yes ____ No _____

Do you have a history of the following?

Back Pain _____

Neck Pain/Whiplash_____

Headaches _____

Numbness _____

Varicose veins/blood clots _____

High Blood Pressure _____

Injury or surgeries (within the last 5 years) _____

Diabetes _____ Wear contacts/other prosthesis? _____

Arthritis _____ Sensitivity to touch in specific areas _____

Cancer/HIV/Leukeumia _____

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

Do you have any of the following TODAY?

☐ Inflammation _____

☐ Headache _____

☐ Open Cuts, bruises, burns_____

☐ Irritated skin rash/poison ivy _____

☐ Cold/fFever _____

Please rate your consumption/participation in the following categories

	None	Light	Moderate	Heavy
Salt	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Water	☐	☐	☐	☐

I am aware that massage therapy is not a substitution for medical care and that a massage therapist can not diagnose or prescribe medicines. I have, to the best of my knowledge, made the therapist aware of my health conditions. I will inform the therapist of any discomfort during the massage or of any change in my health status. I am over 18 years of age.

Signature: _____ ***Date:*** _____

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