

Client Information



Name: _____ Phone: (_____) _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Age: _____ Gender: _____

Referred by: _____ If by search engine, terms used: _____

Emergency Contact: _____ Phone: (_____) _____

Please take a moment to carefully complete the following information and sign where indicated. Some medical conditions and symptoms do not respond well to massage. A referral from your primary care provider may be required prior to service being provided.

Yes No Have you ever received professional massage or bodywork before? How recently? _____

Yes No Are you allergic to any nuts, oils, lotions, or herbs? If so, explain: _____

If you answer "Yes" to any of the following questions, please explain as clearly as possible.

Yes No Do you frequently suffer from stress?

Yes No Do you have diabetes?

Yes No Do you experience frequent headaches?

Yes No Are you pregnant?

Yes No Do you suffer from arthritis?

Yes No Are you wearing contact lenses?

Yes No Do you have high blood pressure?

Yes No If so, are you taking medication?

Yes No Do you suffer from epilepsy or seizures?

Yes No Do you suffer from joint swelling?

Yes No Do you have varicose veins?

Yes No Do you have any contagious diseases?

Yes No Do you have osteoporosis?

Yes No Do you have any allergies?

Yes No

Yes No Have you had a broken bone in the past 2 years?

Yes No Have you been in an accident or suffered any injuries in the past 2 years? _____

Yes No Do you have tension or soreness in a specific area? Please describe: _____

Yes No Do you have cardiac or circulatory problems?

Yes No Do you suffer from low back pain?

Yes No Do you have numbness or stabbing pain?

Yes No Are you sensitive to touch or pressure anywhere?

Yes No Have you ever had surgery? Please explain. _____

Do you have any other medical conditions I should know about or are you taking any medications? Explain below.

Comments: _____

- I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation 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.

- I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of.

- I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing done or said in the course of the session given should be construed as such.

- Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

Client Signature: _____ Date: _____

Consent to Treatment of Minor: By my signature below, I hereby authorize Lynn K. Patricia (Massage Geek) to administer massage, bodywork or somatic techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian: _____ Date: _____