Deep Myo Massage

Professional Massage Therapy

CLIENT INFORMATION

Name;_____ **Phone (Home):(_____)**_____

Address:_____ **Phone (Work):(_____)**_____

City: _____ **State:** _____ **Zip:**_____

Birthdate(M/D/Y):_____ **Age:**_____ **(If under 18 please see 2nd page**

Referred By: _____ **Email:**_____

Employed by:_____ **Occupation:**_____

GENERAL AND MEDICAL INFORMATION:

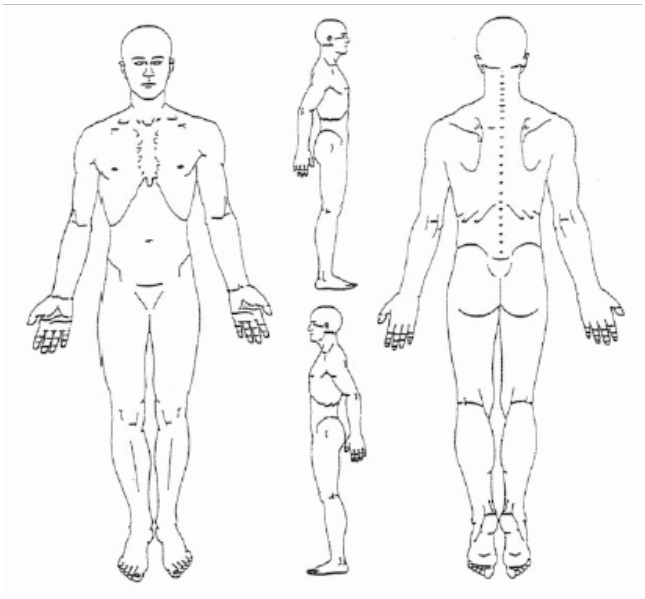
YES	NO	
☐	☐	Have you had a professional massage before? Date of last massage:_____
☐	☐	Have you ever had surgery? Explain:_____
☐	☐	Have you recently been in an accident? Date(s):_____
☐	☐	Do you have any spinal problems? Explain:_____
☐	☐	Do you have chronic back pain? Where?_____
☐	☐	Do you have numbness or stabbing pains anywhere? Where?_____
☐	☐	Do you have tension or soreness in a specific area? Where?_____
☐	☐	Are you sensitive to touch/pressure in any area? Where?_____
☐	☐	Do you have arthritis or joint problems? Where?_____
☐	☐	Are you under Chiropractic care? Why?_____
☐	☐	Are you under Doctors care? Why?_____
☐	☐	Do you take any prescribed medications? Explain:_____
☐	☐	Have you ever had cancer? Explain:_____
☐	☐	Are you pregnant? Due date (M/D/Y): _____
☐	☐	Do you have cardiac or circulatory problems?
☐	☐	Are you diabetic?
☐	☐	Do you have high blood pressure?
☐	☐	Do you have varicose veins?
☐	☐	Are you epileptic?
☐	☐	Do you get frequent headaches?

What do you perceive your stress level to be? Low_____ Moderate ____ High ____
What is your caffeine consumption? Low ____ Moderate ____ High ____

Describe any exercise program or physical activities you regularly do:

_____

Circle any specific areas you would like the massage therapist to concentrate on during the session



DISCLAIMER:

I understand that the massage therapy given is for the purpose of therapeutic care, stress reduction, relief from muscular tension or spasm, or for increasing circulation.

I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist prescribes neither medical treatment nor pharmaceuticals, nor performs any spinal manipulations. It has been made very clear to me that this massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Because massage/bodywork is contra-indicated (should not be done) 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 forget to do so.

CANCELLATION POLICY:

I have a 24 hour cancellation policy. Appointments made with credit cards are subject to charges for the full service amount for "no shows" or for cancellations made less than 24 hours prior to the scheduled appointment time. Kindly call to give 24 hour notice.

If you are booking your massage within 24 hours of the actual appointment and "no show" there is no cancellation and you will be charged the full amount of the appointment.

Patient Signature:_____ Date:_____

If Client is under 18 years of age then a parent or guardian must sign this form before the massage can be performed.

I hereby give permission for my son/daughter or other _____ to receive a therapeutic massage to be performed by Suzanne Remington. I have reviewed this client information form and all the information herein is accurate to the best of my knowledge.

Parent/Guardian Signature:_____ Date:_____