Accent On Massage

Name _____ Birth Date _____

Address _____

City _____ State _____ Zip _____

Telephone _____ Mobile phone _____ email _____

Emergency contact _____

Occupation _____ Referred by _____

What do you do for exercise? _____ How often? _____

Previous experience with massage? _____ What kinds? _____

Reason for coming today _____

Are you currently under the care of a physician? _____

List of any current medications? _____

_____

Are you Pregnant? _____
Are you wearing contact lenses? _____
Do you have any allergies?_____

Medical History

Please check any of the following conditions or symptoms that apply to you now or in the past:

❒ High blood pressure	❒ Heart condition	❒ Varicose Veins	❒ Low blood pressure
❒ Diabetes	❒ Recent surgery	❒ Bone fracture	❒ Osteoporosis
❒ Back, Hip pain	❒Tendonitis	❒ Muscle cramp	❒ Neck, shoulder pain
❒ Frequent headaches	❒ Migraines	❒ Insomnia	❒ Depression
❒ Jaw pain /TMJ	❒ Scoliosis	❒ Sciatica	❒ Arthritis
❒ Easy Bruising	❒ Skin Sensitivity	❒ Asthma	❒ Implants

Others: _____

_____

☆ ☆ ☆ Important ☆ ☆ ☆

☆ I understand that Massage Therapy and Bodywork services does not constitute medical treatment. I acknowledge that massage is not a substitute for a medical examination or diagnosis. It is recommended that I see my primary health care provider for that service.

☆ If I am uncomfortable or experience pain during a session, I agree to communicate with the therapist during a session.

☆ I will inform the massage therapist of any changes in my health status before my next massage.

☆ If I am not able to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case, I will call As soon as possible to reschedule my appointment. Arriving late may result to a shorter session.

☆ Payment is expected on the day of the session.

☆ Clients are protected under 100% confidentiality.

Name _____ Signature _____ Date _____