Client Form

All information gathered on this form is confidential. You will not be contacted unless it relates to your massage appointment. Please print legibly.

Name_____ Home Phone_____

Address_____ Work Phone_____

City/State/Zip_____

Occupation_____

E-Mail Address (Home) _____

E-Mail Address (work) _____

What is your primary reason for seeking a professional massage? Area of complaint, pain or tension (where does it hurt?) _____

_____

Do you have any active or dormant communicable diseases? (Hepatitis, Ringworm, Poison Ivy, etc.) _____

If yes, describe_____

Birth Date_____

My Stress Level is: [ ] Low. [ ] Moderate [ ] Normal [ ] High [ ] Very High

I am [ ] Male [ ] Female Are you pregnant? [ ] Yes. [ ] No

Please list all conditions for which you have received or are currently receiving medical treatment in the past 3 years:

_____

Please List any prescriptions or over-the-counter medications or supplements you are taking: _____

_____

Please read and sign before proceeding to the next page.

I the undesigned, understand that the massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm, or for increased circulation and energy flow. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. The massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. It has been made very clear to me that this massage is not a substitute for a medical examination and/or diagnosis and that it has been recommended I see a physician for any physical ailment. Because the massage therapist must be made aware of any existing physical conditions. I Have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort. I understand there is no sexually contact involved or connotation implied. It will result in the immediate end of the session. I agree to be responsible for all charges incurred. Payment is due in full when services are rendered. Deanna Uhl does not accept insurance assignment. We reserve the right to refuse treatment to anyone. I AGREEE THAT I MAY BE CHARGED FOR MISSED APPOINTMENTS WITH LESS THAN 24 HOUR NOTICE AND IF I'M LATE FOR AN APPOINTMENT. I MAY BE CHARGED FOR THE FULL AMOUNT OF TIME ALLOTTED EVEN THOUGH THE ACTUAL MASSAGE MAY BE SHORTER.

*Signature*_____ *Date*_____

Please continue on the next page>>>>>>>>>

How would you rate your health? ☐ Excllent ☐ Good ☐ Fair ☐ Poor

Do you wear: ☐ Dentures ☐ Contact Lenses ☐ Prosthesis

Do you eat a balanced diet? _____

How much water do you drink each day? (Recommended consumption is ½ your body weight in ounces) _____

Do you have any history of muscular or skeletal disease or injury? _____

If yes, please specify: _____

Please circle any of the following conditions that apply to you: Abdominal Pain Chronic Fatigue Fibromyalgia Allergies Carpal Tunnel Syndrome Whiplash Depression Heart Disease High Blood Pressure Low Blood Pressure Diabetes Arthritis Migraine Headaches Sinusitis or Sinus Problems Breast Augmentation or Reduction Spinal Problems Varicose Veins

Please use this body map to indicate with an "X" or by Circling the areas which are causing you discomfort. Feel free to make notes in the margins.