Stillwaters Therapeutic

Name_____ Phone _____Mobile_____

Address_____City/State/Zip_____

Email_____ Occupation _____

Date of Birth_____ Referred by: _____

Emergency Contact _____ Phone_____

The following information will be used to help your therapist plan a safe and effective massage session. Please answer the questions to the best of your knowledge.

Have you had a professional massage before? Yes No If yes, how often? _____

Do you have any difficulty lying on your front, back, or side? Yes No

If yes, please explain_____

Do you have any allergies to oils, lotions, ointments, fruits or nuts? Yes No

If yes, please explain _____

What type of pressure do you prefer? **LIGHT** **MODERATE** **FIRM** **DEEP TISSUE**

Are you wearing: ☐ contact lenses ☐ dentures ☐ a hearing aid ☐ prosthetics? Do you have a Pacemaker? ☐ YES ☐ NO

Do you sit for long hours at a workstation, computer, or driving? Yes No

If yes, please describe _____

Do you perform any repetitive movement in your work, sports, or hobby? Yes No

If yes, please describe _____

How do you feel the stress in your work, family, or other aspect of your life affected your health?

☐ muscle tension ☐ anxiety ☐ insomnia ☐ irritability ☐ other_____

Is there a specific area of the body where you are experiencing tension, stiffness, pain or discomfort?

Yes No If yes, please identify_____

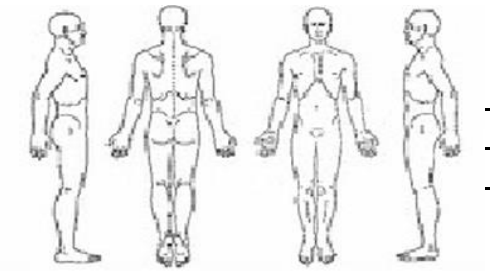
Do you have any particular goals in mind for this massage session? Yes No

If yes, please explain_____

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

AREAS TO AVOID:

_____
_____
_____



AREAS TO CONCENTRATE ON:

_____
_____
_____

Medical History

Do you currently or have you ever had any of the following: (please check)

☐phlebitis	☐tennis elbow	☐deep vein thrombosis/blood clots
☐recent fracture	☐ joint disorder	☐recent surgery
☐rheumatoid arthritis	☐osteoarthritis	☐tendonitis
☐artificial joint	☐osteoporosis	☐sprains/strains
☐epilepsy	☐current fever	☐headaches/migraines
☐swollen glands	☐cancer/tumors	☐allergies/sensitivity
☐diabetes	☐heart condition	☐digestive disorder
☐high or low blood pressure	☐back/neck problems	☐circulatory disorder
☐ Fibromyalgia	☐varicose veins	☐TMJ
☐atherosclerosis	☐carpal tunnel syndrome	☐easy bruising
☐contagious skin condition	☐recent accident or injury	☐open sores or wounds
☐asthma	☐pregnancy	If yes, how many months? _____

Are you currently under medical supervision? Yes No

If yes, please explain_____

Do you see a chiropractor? Yes No If yes, how often?_____

Do you see an acupuncturist? Yes No

Are you currently taking any medication? Yes No

If yes, please list _____

Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you? _____

_____

Consent for Treatment

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/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 of which I am aware. 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 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. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Signature of client _____ Date _____

Signature of Massage Therapist _____ Date _____