Client Information

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

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

Referred by: _____ Telephone: ( )_____

In case of emergency: _____ Telephone: ( ) _____

General & Medical Information
Occupation: _____ Age: _____ Male Female Physician: _____

Health Insurance Carrier: _____

Please take a few moments to carefully read the following information and sign where indicated. If you have a specific medical condition or symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to the service being provided.

Yes No Have you ever experienced a professional massage or bodywork session? How recently? _____

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 Are you wearing contact dentures?
Yes No Do you have high blood pressure?
Yes No If "yes" to previous question, are you taking medication for this?
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 osteoporosis?
Yes No Do you have any allergies?

Yes No Do you bruise easily?
Yes No Have you had any broken bones in the past 2 years?
Yes No Have you been in an accident or suffered and injuries in the past 2 years?
Yes No Do you have tension or soreness in a specific area? Please specify: _____
_____
_____
Yes No Do you have cardiac or circulatory problems?
Yes No Do you suffer from back pain?
Yes No Do you have numbness or stabbing pains anywhere?
Yes No Are you very sensitive to touch or pressure in any area(s)
Yes No Have you ever had surgery? If so, Explain. _____
_____
Yes No Do you have any other medical Conditions or are you taking any Medications? _____
_____
Yes No Do you have any contagious diseases?
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 medical 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 of the session, and I will be liable for payment of the scheduled appointment.

Client Signature: _____ Date: _____

Consent to Treatment on Minor: By my signature below, I herby authorize Shannon Schueller to administer massage, bodywork or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian: _____ Date: _____