Jamie's Therapeutic Touch

CLIENT INFORMATION

Name:_____ DOB:_____

Address_____ City, State, Zip_____

Phone#_____ Referred By_____

Email:_____

In which areas of your body are you experiencing discomfort?_____

Are there any areas that you would like me to avoid?_____

Have you had a professional massage before? YES NO If yes, what kind?_____

PLEASE DESCRIBE YOUR GENERAL HEALTH CONDITION:
EXCELLENT GOOD FAIR POOR

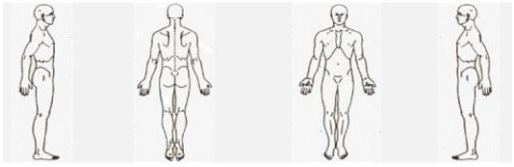
Please check all that apply:

__Bruise easily	__Pregnant	__Arthritis	__Allergies
__Carpal Tunnel	__Diabetes	__Varicose Veins	__Depression
__High Blood Pressure	__Epilepsy	__Blood Clots	__Anxiety
__Cardiac problems	__TMJ (jaws)	__Asthma	__Sinus
__Psychotherapy	__Sciatica	__Contagious Disease	__Cancer
__Respiratory Problems	__Migraines		

Are you currently under medical supervision? YES NO
If yes, please explain_____
Are you currently taking any medications? YES NO
If yes, please list_____
Have you had a serious injury or surgery? Please explain._____
If so, do you have any surgical pins, plates or artificial joints? Where? _____
Have you been in an accident within the last 72 hours?_____
Are there any other medical conditions I should be aware of?_____
Type of massage I prefer to have is (Please circle).....Swedish, Deep Tissue, Hot Stone, Pre-natal, other
Informed Consent: (***Please take a moment to thoroughly read).***

Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

Please indicate with an (X), if any, the areas in which you are feeling discomfort



I, _____understand that the massage 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 therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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 that I am aware of. I understand that massage therapists 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 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I understand that breast massage will not be performed, and proper Draping will be used during the session - only the area being worked on will be uncovered. . If at any time during my massage I feel uncomfortable, I may request that the therapist stop the session.

Signature of Client_____ Date_____

Signature of Massage Therapist_____ Date_____

MT Establishment # ME1713