

SEDONA MASSGE CO. CLIENT HEALTH HISTORY

Name: _____ Phone: _____ HM/CELL
Address: _____ City: _____ State: _____ Zip: _____
Age: ___ Date of Birth: ___/___/___ Occupation: _____ Referred by: _____
Emergency contact: _____ Relationship: _____ Phone: _____
Would you like to be notified of specials? ___No ___Yes E-mail: _____

CURRENT HEALTH

Have you ever received massage therapy before? ___Yes ___No Frequency _____
What kind of pressure do you prefer? ___Light ___Medium ___Firm ___Deep
Reason for today's visit: ___Injury/Strain ___Relaxation ___Hair Removal ___Spa Modality ___Nutrition
Classify concern: ___Minor ___Problematic ___Major
Classify type: ___Recurring ___Getting Worse ___Getting Better
Desired result/goal of today's session _____
Have you received treatment for this before? ___Yes ___No Explain: _____
List activities affected: _____
Current medications (Rx, OTC, Herbal, etc.) _____
Exercise activities and frequency: _____
Check any of the following that apply to your current health:
___Pregnancy ___Diabetes ___Heart Condition ___Circulatory Condition ___Blood Clots ___Cancer
___Infections ___Difficulty Breathing ___Arthritis ___Tense Muscles ___HIV/AIDS ___Allergies
___Low / High Blood Pressure ___Spinal Injury/Surgery ___Headaches ___Varicose Veins ___Other

MEDICAL HISTORY (list in chronological order; give dates or ages and treatment received)

Surgeries: _____
Accidents: _____
Major Illnesses: _____

If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A Referral from your primary care provider may be required prior to receiving massage therapy.

CONSENT FOR CARE

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that breast massage will at no time be part of my therapy. I also understand that the effectiveness of individual techniques or series of appointments may vary. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all of my known medical conditions and will inform my therapist of any changes in my health status. 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. I have answered all questions honestly. I understand that there will be no liability on the practitioner's part should I fail to update and inform my therapist of any medical changes verbally or written. 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.

Types of anticipated massage techniques to be used in this and subsequent sessions: Swedish, Deep Tissue, Trigger Point, Reflexology, Sports Massage, Energy Work, CranioSacral, Resistance Stretching, Pointer Plus, Magnetic Cupping, Massage Cupping, Moist/Dry Infrared Heat, Hot Stone Therapy, Aromatherapy, Pregnancy Massage, Audio Therapy, Art Therapy, Paraffin Dip, Mud Wrap, Herbal Wrap, Cocoon Wrap, Aerobic Exerciser, Medical Massage, Alexandria Professional Body Sugaring (hair removal), as requested by client and with associated fees for different modalities. This is a full draping establishment.

ALL CLIENTS ARE RESPONSIBLE FOR PAYMENT AT TIME OF VISIT. AN INVOICE BILL WILL BE PROVIDED FOR INSURANCE REIMBURSEMENT.

Client's Signature _____ Date _____
Therapist's Signature _____ Date _____