

### Client Data and Health Screen

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Birth date \_\_\_\_\_  Male  Female

Email: \_\_\_\_\_ Referred by \_\_\_\_\_

In case of emergency contact \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Occupation \_\_\_\_\_

**Please take a moment to carefully read the following information and sign where indicated. 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 service being provided.**

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

What are you massage/bodywork goals? \_\_\_\_\_

What kind of pressure do you prefer?  light  medium  firm/deep

**Please indicate if you have any of the following conditions and explain as clearly as possible.**

- |   |  |
|---|--|
| <input type="checkbox"/> Abscess or open sore     | <input type="checkbox"/> Herpes I or II                            |
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> HIV Positive                              |
| <input type="checkbox"/> Arteriosclerosis         | <input type="checkbox"/> Hypertension                              |
| <input type="checkbox"/> Cancer/malignancy        | <input type="checkbox"/> Injuries or broken bones (past two years) |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Inner ear problem                         |
| <input type="checkbox"/> Currently Pregnant       | <input type="checkbox"/> Mental illness                            |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Numbness - Specify: _____                 |
| <input type="checkbox"/> Easy bruising            | <input type="checkbox"/> Osteoarthritis                            |
| <input type="checkbox"/> Epilepsy/seizures        | <input type="checkbox"/> Osteoporosis                              |
| <input type="checkbox"/> Fibromyalgia             | <input type="checkbox"/> Phlebitis                                 |
| <input type="checkbox"/> Fibrositis               | <input type="checkbox"/> Rheumatoid arthritis                      |
| <input type="checkbox"/> Fluid retention          | <input type="checkbox"/> Skin rash                                 |
| <input type="checkbox"/> Fractures                | <input type="checkbox"/> Skin sensitivity                          |
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Varicose veins                            |
| <input type="checkbox"/> Heart disease            | <input type="checkbox"/> Other infectious disease: _____           |

Do you wear contact lenses \_\_\_\_\_, dentures \_\_\_\_\_, hearing aid \_\_\_\_\_ or have any implants \_\_\_\_\_?

Do you have any other medical condition, or are you taking any medications that I should know about? Please specify:

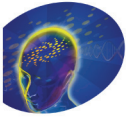
\_\_\_\_\_  
\_\_\_\_\_

Do you have any tension or soreness in a specific area? Please specify: \_\_\_\_\_

\_\_\_\_\_

Are you under the care of a physician or other medical practitioner now? If so, for what condition? \_\_\_\_\_

\_\_\_\_\_



Do we have permission to contact your physician should the need arise?  Yes  No

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

This information will be treated confidentially. In order to maximize the effectiveness and safety of massage sessions together, please give your feedback during and at the end of the sessions. This will help in tailoring the massage session to serve you in the best possible way.

I understand that the massage/bodywork I receive is provided for the basic purpose and relief of muscular tension. If I experience any pain or discomfort during the 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.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Consent to Treatment of Minor.** By my signature, I hereby authorize New Horizons Massage, LLC, to administer massage, bodywork or somatic therapy techniques to my child or dependent as necessary.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_