New Horizons Massage, LLC

t: 240 626 3215
e: paul@newhorizonsmassage.com
www.newhorizonsmassage.com

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.

____Abscess or open sore
____Allergies
____Arteriosclerosis
____Cancer/malignancy
____Chronic Fatigue Syndrome
____Currently Pregnant
____Diabetes
____Easy bruising
____Epilepsy/seizures
____Fibromyalgia
____Fibrositis
____Fluid retention
____Fractures
____Headaches
____Heart disease
____Herpes I or II
____HIV Positive
____Hypertension
____Injuries or broken bones (past two years)
____Inner ear problem
____Mental illness
____Numbness - Specify:_____
____Osteoarthritis
____Osteoporosis
____Phlebitis
____Rheumatoid arthritis
____Skin rash
____Skin sensitivity
____Varicose veins
____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? _____

_____

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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: _____