

Today's Date: ___/___/___

Client Information

Name: _____ DOB: ___/___/___ Sex: M F
(First) (Last)

Address: _____ Apt _____

City: _____ State: _____ Zip: _____

Email: _____
(please print clearly)

Preferred Contact

Home Phone: (____) _____

Occupation: _____

Cell Phone: (____) _____

Would you like to receive text specials? Y N

Emergency Contact _____
(Name & Phone#)

The following information will allow your therapist to provide you with the best session possible

This information is strictly confidential to Healing Hands Massage staff. We do not share information with any other outside individuals or companies.

Please share your goals for this session _____

- Do you perform repetitive movements in your work, sports or hobby? Y N
- Do you sit for long hours at a computer or while driving? Y N
- Are you currently experiencing tension, stiffness, discomfort or pain? Y N
- If yes, does it limit your movement in any way? Y N
- Have you been involved in a motor vehicle accident in the past 12 months? Y N
- Have you recently had any injury, surgery or areas of inflammation? Y N
- Do you bruise easily? Y N
- Do you have sensitive skin? Y N
- Are you currently pregnant? Y N If yes, how far along _____
- Have you had a professional massage before? Y N

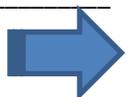
Health History (please check any conditions you have experienced in the past 12 months, or are currently experiencing)

- | | | |
|---|--|---|
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> IBS |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Bladder/Kidney Ailment |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Anxiety/Stress |
| <input type="checkbox"/> Varicose Veins/Phlebitis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Muscle Strains | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> Cancer/Tumors |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Herpes/Cold Sores | <input type="checkbox"/> Tourette's |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Shingles | <input type="checkbox"/> Autism/Asperger |
| <input type="checkbox"/> Whiplash | <input type="checkbox"/> Disc Bulge/Herniation | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Spinal Stenosis | <input type="checkbox"/> Ligament Sprains | <input type="checkbox"/> Rotator Cuff Tear |

Please use this space to list any other conditions or details on those checked above.

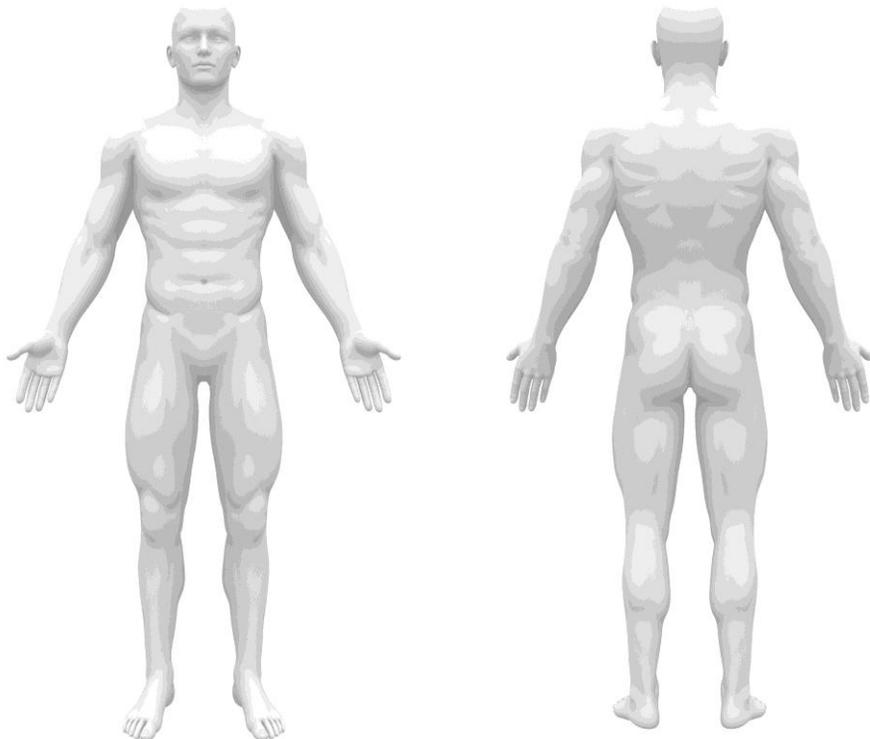
Please list all current medications _____

(Cont'd on Reverse)



Please list any allergies _____

Please list any sports or exercise you participate in regularly _____



Please mark, on the diagram, any specific areas in which you are experiencing soreness, pain or discomfort.

Feel free to provide any details as necessary

I understand that any therapy session I receive with Healing Hands Massage, is provided strictly for the basic purpose of relaxation and relief from stress and tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist. I affirm that I have stated all known medical conditions and understand that there shall be no liability on the therapist's part if massage is contraindicated. (We suggest a physician's consent if there is any question)

I also understand that all therapy sessions are strictly therapeutic and that any illicit or sexually suggestive remarks or advances on my part will result in immediate termination of the session and I will be liable for payment in full.

I am aware that I am required to give a minimum of four (4) hours notice to cancel any appointments, regardless of when they were made. I will be responsible for full payment if failing to do so.

Special Note: All massage therapists are under contract with Healing Hands Massage and are not legally permitted to independently massage any Healing Hands Massage client without written consent from one of the owners.

X _____
Signature of Client (or Guardian if a minor)

Date _____

Who can we thank for your visit? Referred by: _____