MASSAGE CLIENT REGISTRATION Date: _____

Client Name: _____ Gender: o M o F

Date Of Birth: _____

Address:_____

City: _____ State: _____ Zip: _____ Phone _____

Email_____

Where do you work (what kind of work do you do?)_____

Emergency Contact _____ Phone _____

Medical History and Information

Check any or all that apply to your present health:

___ headaches	___chronic pain	___varicose veins
___ vision problems	___muscle or joint pain	___blood clots
___ sinus problems	___numbness/tingling	___high/low blood pressure
___ jaw pain/teeth grinding	___sprains/strains	___diabetes
___ fatigue	___scoliosis	___cancer/tumors
___ depression	___arthritis	___infectious disease
___ sleep difficulties	___tendonitis	___skin problems or allergies

Women only: ___Pregnant___ Painful menstruation___ endometriosis

Other not listed_____

List all medications/herbs/vitamins and dosage: _____

What movements or activities are limited? (what aggravates it?)_____

Previous major injuries/surgeries:_____

What other treatments are you receiving and by whom: _____

Massage Therapy Informed Consent

I, _____, (client) understand that massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension. It has the potential to increase range of motion, improve circulation and offer a positive experience of touch. The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy. I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information. If I experience any pain or discomfort during the session, I will immediately communicate that to the therapist so the treatment can be adjusted. I have reviewed the therapist's policies, and I understand them and agree to abide by them. I acknowledge that any treatment can contain risks and I assume those risks.

Client Signature Date

_____ _____ _____