FACE + BODY
STUDIO

Personal Information

Name _____ Phone (day)_____(evening) _____

Address _____ City/State/Zip_____DOB _____

Occupation_____Employer _____

Email_____Primary Physician _____

Emergency Contact_____Relationship_____Phone _____

How did you hear about us? _____

Medical Information

Are you taking any medications? ☐yes ☐no

If yes, please list name and use: _____

_____

Are you currently pregnant? ☐yes ☐no

If yes, how far along?_____

Any high risk factors? _____

Do you suffer from chronic pain? ☐yes ☐no

If yes, please explain_____

What makes it better?_____

_____

What makes it worse?_____

_____

Have you had any orthopedic injuries? ☐yes ☐no

If yes, please list:_____

Please indicate any of the following that apply to you.

☐ Cancer
☐ Headaches/Migraines
☐ Arthritis
☐ Diabetes
☐ Joint Replacement(s)
☐ High/Low Blood Pressure
☐ Neuropathy
☐ Fibromyalgia
☐ Stroke
☐ Heart Attack
☐ Kidney Dysfunction
☐ Blood Clots
☐ Numbness
☐ Sprains or Strains

Explain any conditions you have marked above:

_____

_____

Massage Information

_____

Have you had a professional massage before? ☐yes ☐no

What type of massage are you seeking?

☐ Relaxation ☐Therapeutic/Deep Tissue

Other _____ What pressure do you prefer?

☐ Light ☐Medium ☐Deep

Do you have any allergies or sensitivities? ☐yes ☐no

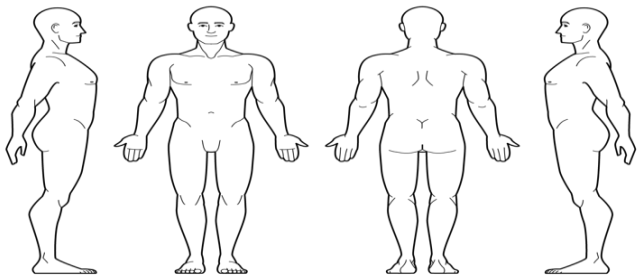
Please explain _____

Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐yes ☐no

Please explain_____

What are your goals for this treatment session?

Please circle any areas of discomfort



By signing below, you agree to the following.

I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ *Date* _____

Therapist Signature _____ *Date* _____

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General Liability Release Form

By signing below, you agree to the following:

1) I give my permission to receive massage therapy.

2) I understand that therapeutic massage is not a substitute for traditional medical treatment or medications.

3) I understand that the massage therapist does not diagnose illnesses or injuries, or prescribe medications.

4) I have clearance from my physician to receive massage therapy.

5) I understand the risks associated with massage therapy include, but are not limited to:

- *Superficial bruising*
- *Short-term muscle soreness*
- *Exacerbation of undiscovered injury*

I therefore release the company and the individual massage therapist from all liability concerning these injuries that may occur during the massage session.

6) I understand the importance of informing my massage therapist of all medical conditions and medications I am taking, and to let the massage therapist know about any changes to these. I understand that there may be additional risks based on my physical condition.

7) I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so he/she may adjust accordingly.

8) I understand that I or the massage therapist may terminate the session at any time.

9) I have been given a chance to ask questions about the massage therapy session and my questions have been answered.

*Signature*_____

*Date*_____