



Name _____ Phone (____) _____ DOB _____

Address _____ City _____ State _____ Zip _____

E-mail _____

In case of emergency _____

ICE Phone _____ ICE Relationship: _____

Found Us How?: ☐ Yelp ☐ Google Referred By: _____

Occupation: _____

Preferred contact method for Appointments? Please check box. ☐ Call ☐ Text ☐ Email

Would you like to be on our mailing list for discounted promotions? ☐ Yes ☐ No

What are your massage or bodywork goals? _____

What kind of pressure do you prefer? ☐ light ☐ medium ☐ firm

Week of Pregnancy: _____ Expected Due Date: _____

Physician Name/Number: _____

Physician Approve Massage? ☐ Yes ☐ No

Please Check any complication or condition you may have experienced in this pregnancy.

- | | |
|---|--|
| <input type="checkbox"/> Multiple pregnancy (twins) | <input type="checkbox"/> Varicous veins |
| <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Pleactal dysfunction | <input type="checkbox"/> Leg cramps |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Restless legs |
| <input type="checkbox"/> Pre-eclampsia | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Threatened miscarriage | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Premature labor | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Bladder infection | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Swollen hands and/or feet | <input type="checkbox"/> Difficulty sleeping |

Do you have tension or soreness in a specific area?

☐ Yes ☐ No

Please specify _____

Other medical condition, or are you taking any medications I should know about?

☐ Yes ☐ No

Please specify _____

Any injuries in the past 2 Years? ☐ Yes ☐ No

Any surgeries in the past 2 Years? ☐ Yes ☐ No

Do you bruise easily? ☐ Yes ☐ No

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