Contact Information

Name ____ Date of Birth __________________

Phone __________________________ E-mail ____

Address ___________________________________ City ______________ State _____ Zip ________

Occupation _______________________________ Referred by __________________________________

Emergency contact ____ Phone ___________________

Massage Information

Have you ever received professional massage therapy before? □ Yes □ No

How recently? ____

How much pressure do you prefer? □ Light □ Medium □ Deep

What are your goals regarding massage therapy? □ Relaxation □ Treatment

How often do you receive massage? □ Weekly □ Bi-weekly □ Monthly □ Quarterly □ Occasionally

Area(s) of chronic pain/tension ____

Area(s) therapist should avoid ____

In general, how would you rate your stress level? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Do you have any special needs or concerns related to massage? (i.e. temperature, music, lotion/oil sensitivities)

____

____

Health Information

Current medications/nutritional supplements ____

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Massage therapy may be contraindicated for individuals with certain medical conditions; a medical release from your physician may be required before massage. ***Please check any of the following conditions you currently have:***

- □ **infections/contagious conditions**
- □ **pitted edema**
- □ **kidney failure**
- □ **uncontrolled high blood pressure**
- □ **high risk pregnancy**
- □ **blood clots**
- □ **congestive heart failure**
- □ **cancer**

Health Information (continued)

Please indicate any conditions you have now or have had previously, *including year and treatment received*:

Current	Past	Condition
☐	☐	Muscle or joint pain/stiffness ____________________
☐	☐	Broken bones ____________________
☐	☐	Numbness or tingling/neuropathy ____________________
☐	☐	Degenerative spine/disk ____________________
☐	☐	Osteoporosis ____________________
☐	☐	Scoliosis ____________________
☐	☐	Headaches/migraines ____________________ Frequency __________
☐	☐	Arthritis (rheumatoid/osteoarthritis) ____________________
☐	☐	High/low blood pressure ____________________
☐	☐	Diabetes ____________________
☐	☐	Digestive disorder (Crohn's, IBS) ____________________
☐	☐	Autoimmune disorders ____________________
☐	☐	Fibromyalgia ____________________ # points positive: __________
☐	☐	Epilepsy/seizures ____________________
☐	☐	Cancer ____________________
☐	☐	Respiratory issues (asthma, etc) ____________________
☐	☐	Allergies/skin sensitivities ____________________
☐	☐	Depression/anxiety ____________________
☐	☐	Insomnia ____________________
☐	☐	Stroke/heart disease ____________________
☐	☐	High/low blood pressure ____________________
☐	☐	Thyroid disorder ____________________
☐	☐	Reproductive (hysterectomy, dysmenorrhea) ____________________
☐	☐	Other ____________________
☐	☐	Other ____________________

Consent for Treatment

I hereby affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep my therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I authorize Kristen Seaton, LMT to administer massage, bodywork, somatic therapy techniques and/or aromatherapy as she deems necessary. I understand that massage therapy is not a substitute for medical attention, and that massage therapists are not qualified to perform spinal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said during the course of the session given should be construed as such.

Client signature ______________________________ Date ____________

Parent or guardian signature (in case of minor) ______________________________