Paris Holistic Health

** Massage Client Information Form**

 (Please Print)

**General Information:**

Name: Date of Birth:

Address:

Home Phone: Cell: Work Phone:

Email: € Add me to your mailing list

Emergency Contact (Name and Phone):

How did you hear about us?

**Health Information:**

Are you currently under the care of a physician (if yes, list diagnosis)?

Are you currently seeing a chiropractor (if yes, list issue)?

Are you currently seeing a physical therapist (if yes, list issue)?

List Medications, Supplements, Homeopathics and Herbs (list reason for medication and any side effects e.g. drowsiness/dizziness, difficulty walking/standing, visual impairment, any other):

List Surgeries with Dates:

List Accidents and Injuries with Dates:

Do you have a particular area of concern?

Are you pregnant (if yes, how many weeks)?

Do you have any symptoms of illness (e.g. fever, chills, nausea)?

(this is a contraindication to massage and the massage will have to be rescheduled)

**Conditions by Body System (Please circle all that apply)**

**Skin:** open sores, rash, warts, hives, cold sore/herpes, skin cancer, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Bone:** fracture, osteoporosis, bone disease, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Joint:** arthritis, gout, sacroiliac pain, TMJ, joint disease, sprain, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Musculoskeletal:** strain, spasms/cramps, whiplash, tendonitis/bursitis, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Circulatory:** high/low blood pressure, orthostatic hypotension, heart condition, phlebitis/varicosities, blood clots, bruises, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Respiratory:** asthma, emphysema/COPD, sinusitis, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lymphatics:** swollen glands, nasal congestion, lymph edema, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nerves:** pinched nerve, numbness/tingling, sciatica, shingles, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Endocrine:** diabetes, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Autoimmune Disease:** lupus, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Conditions:** headaches, migraines, grind teeth, allergies, chronic diarrhea/constipation, cancer/tumors, chronic fatigue, anxiety, stress, HIV/AIDS, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Treatment History and Guidance:**

Have you ever had a professional massage (if yes, how many)?

When was your last session?

Circle the type of pressure you like: Light Medium Firm

What areas require extra attention?

Are you sensitive to touch (ticklish)/pressure (if yes, list areas)?

Are there other areas you wish to be avoided?

Are you allergic or sensitive to scents or oils (if yes, list details)?

Do you need help getting on/off the massage table?

Indicate areas of pain/tension on appropriate diagram. Rate pain on a scale of 1 (mild) – 10 (unbearable).

What caused the pain?

**Privacy Notice:**

All information provided herein will be kept confidential. No information will be discussed or shared with any third party without the express written consent of the client, parent/guardian if the client is under 18, or as required by law.

**Consent to Treatment:**

Please read and initial each statement.

\_\_\_\_ If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my comfort level. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.

\_\_\_\_ I understand that the services offered by my therapist are not a substitute for medical care. I also understand that my therapist does not diagnose or treat illness, disease, or injury and cannot adjust, manipulate, or mobilize any of the articulations of the body or spine.

\_\_\_\_ I acknowledge that massage should not be performed or should be modified if certain medical conditions exist or certain medications are being taken. To the best of my knowledge, I have provided complete and accurate information on all of my medical conditions, injuries and medications. If I have failed to provide complete and accurate medical information, the therapist and facility where the massage was received shall not be held liable.

\_\_\_\_ I acknowledge that massage can increase the likelihood of certain side effects of medications such as sedation and difficulty with balance. I also acknowledge that it can increase the release of certain medications into the system. If I am unaware whether or not my medication precludes me from receiving massage, I will check with my prescribing physician prior to my appointment.

\_\_\_\_ I acknowledge that I am responsible for informing the therapist of any changes in my health, medical conditions, and medications before each appointment. If I fail to do so, the therapist and facility where the massage was received shall not be held liable.

\_\_\_\_ If I require assistance getting on/off the massage table or assistance walking, I will discuss this with the therapist.

\_\_\_\_ I acknowledge that massage is therapeutic and non-sexual in nature. I understand that I do not have to get completely undressed if I am not comfortable doing so. If at any time I do not feel comfortable with the massage, I will discuss my discomfort with the therapist. I acknowledge that I have the right to terminate the session at any time. I also acknowledge that if any sexual misconduct occurs on my part, that the massage session will be terminated and I will be required to pay in full for the session and will not be allowed to return for any future service.

\_\_\_\_ I acknowledge that if I need to cancel an appointment, that I will give 24 hours or more notice. I also acknowledge that I am responsible for the cost of the appointment if I failure to give this notice or failure to show up for an appointment.

\_\_\_\_ By signing this form, I hereby waive and release the massage therapist and the facility where the massage was received from any and all liability past, present and future relating to massage and bodywork.

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

 **(Client’s Parent/Guardian if under 18)**