Ministering Touch Massage Therapy – Client Information

Name _____ Phone (_____) _____ DOB _____

Address _____ City _____ State _____ Zip _____

E-mail: _____

In case of emergency: _____ Phone (_____)_____

❑ Male ❑ Female Occupation _____ Physician_____

Please take a moment to carefully read the following information and sign where indicated. Some medical conditions or specific symptoms may contraindicate massage/bodywork and require a referral from your physician prior to massage.

Have you ever experienced a professional massage or bodywork session? ❑Yes ❑No How recently_____

What are your massage or bodywork goals today? ❑ Relaxation/Stress Relief; ❑ Therapeutic (specify area of concern & goals) _____

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

Are there any areas of your body you do not want massaged today? _____

❑ Yes ❑ No Do you frequently suffer from stress?
❑ Yes ❑ No Do you have diabetes?
❑ Yes ❑ No Do you experience frequent headaches?
❑ Yes ❑ No Are you pregnant?
❑ Yes ❑ No Do you suffer from arthritis?
❑ Yes ❑ No Are you wearing contact lenses?
❑ Yes ❑ No Are you wearing dentures?
❑ Yes ❑ No Do you have high blood pressure?
❑ Yes ❑ No Are you taking high blood pressure medication?
❑ Yes ❑ No Do you suffer from epilepsy or seizures?
❑ Yes ❑ No Do you suffer from joint swelling?
❑ Yes ❑ No Do you have varicose veins?
❑ Yes ❑ No Do you have any contagious diseases?
❑ Yes ❑ No Do you have osteoporosis?
❑ Yes ❑ No Do you have any allergies? (Including herbs, scents, and oils that might used in massage.)

❑ Yes ❑ No Do you bruise easily?
❑ Yes ❑ No Any broken bones in the past two years?
❑ Yes ❑ No Any injuries in the past two years?
❑ Yes ❑ No Do you have tension or soreness in any area?
Please specify _____
_____

❑ Yes ❑ No Do you have cardiac or circulatory problems?
❑ Yes ❑ No Do you suffer from back pain?
❑ Yes ❑ No Do you have numbness or stabbing pains?
❑ Yes ❑ No Sensitivity to touch or pressure in any area?
❑ Yes ❑ No Have you ever had surgery? Explain below.
❑ Yes ❑ No Other medical condition, or medications therapist should know about?

Comments _____
_____

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 _____

Consent to Treatment of Minor: By my signature below, I hereby authorize Nathan Sarvis, LMT, to administer massage, bodywork, or somatic therapy techniques he deems necessary to _____, my child or dependent.

Signature of Parent or Guardian _____ Date _____