Ministering Touch Massage Therapy Client Information and Health History

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? _____

Check only those to which you answer "Yes"

___Do you have any allergies (Including herbs, scents, and oils that might be used in massage)?
___Do you frequently suffer from stress?
___Do you experience frequent headaches?
___Do you suffer from arthritis?
___ Do you suffer from epilepsy or seizures?
___Do you have any contagious diseases?
___Do you have high blood pressure?
___Do you bruise easily?
___Do you suffer numbness or stabbing pains?
___Have you had a tattoo within last 30 days
___ Are you wearing a wig, hairpiece, or hair extensions?
___Do you have diabetes?
___Are you pregnant?
___Do you have varicose veins?
___Do you suffer from joint swelling?
___Do you have osteoporosis?
___Are you taking blood pressure meds?
___Any broken bones/injuries in last two years?
___Sensitivity to touch or pressure in any area?
___Other medical condition, or medications?
___ Have you ever had surgery? Explain below.

_____
_____

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. Massage therapy is not a substitute for medical examination or diagnosis. It is recommended that I see a physician for any physical ailment that I may have. I understand that the massage therapist does not prescribe medical treatments or pharmaceuticals and does not perform any spinal adjustments. I am aware that if I have any serious medical diagnosis, I must provide a physician's written consent prior to services 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. The licensee shall drape the breasts of all female clients and not engage in breast massage of female clients unless the client gives written consent before each session involving breast massage. Draping of the genital area and gluteal cleavage will be used at all times during the session for all clients. If the client is uncomfortable for any reason, the client may ask the licensee to end the massage, and the licensee will end the session. The licensee also has a right to end the session if uncomfortable for any reason.

Client Signature _____ Date _____