

Mountain Massage Therapy, LLC

Client Information

Name: _____ Age: _____ Birth date: _____ Phone: _____

Address: _____ City _____ Zip _____ Email: _____

Occupation: _____ Referred by: Google Facebook Instagram Website Signage Person: _____

Emergency contact: _____ Phone: _____

Have you ever experienced a professional massage or bodywork session? N Y How long ago? _____

General & Medical Information Do you have, had, or suffer from any of the following: (mark all that apply)

Stress (frequent / occasional) _____	High Blood Pressure _____	Stroke _____
Headaches (frequent / occasional) _____	Contagious Disease _____	Seizures _____
Neck pain _____	Cardiac or Circulatory issues _____	Heart Attack _____
Back pain (upper, middle, low) _____	Osteoporosis _____	Arthritis _____
Bruise easily _____	Fibromyalgia _____	Varicose Veins _____
Diabetes (Type I / Type II) _____	Carpal Tunnel _____	Cancer (Type _____)

Numbness or Stabbing pain (if yes where) _____ Are you pregnant? N Y how many months _____

Allergies _____

Have you been in an accident or suffered any injuries including broken bones in the last year? If yes, please explain:

Have you had any surgeries in the last year? If yes where? _____

Please list any additional areas that have tension or soreness not already listed: _____

Do you have any other medical conditions or are you taking any medications not already listed? _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

I understand that the massage/bodywork session 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 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 that I am aware of. I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said during the session should be construed as such.

Because massage 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 not be 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.

Cancellation Policy: A minimum of 24-hour notice of cancellation is required. If I cancel less than 24 hours before my scheduled appointment, I understand a cancellation fee will be added to my next appointment.

Signature: _____ Date: _____