Absolute Body Balance

Personal Information:

Name_____ Phone _____

Address _____

City/State/Zip _____

Email _____ Opt in for Special Email Offers: **Y** **N** Date of Birth _____

Emergency Contact_____ Phone _____

How did you hear about us? _____

(If referred by someone, please list full name)

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

1. Have you had a professional massage before? Yes No

   If yes, how often do you receive massage therapy? _____

2. What are your daily activities?

   i.e. work, hobbies, sports_____

3. Have you had any accidents, injuries, or surgeries that your therapist should be aware of? Yes No

   If yes, please explain_____

4. Do you have any allergies to nuts, fragrance, oils, lotions, etc.? Yes No

   If yes, please explain _____

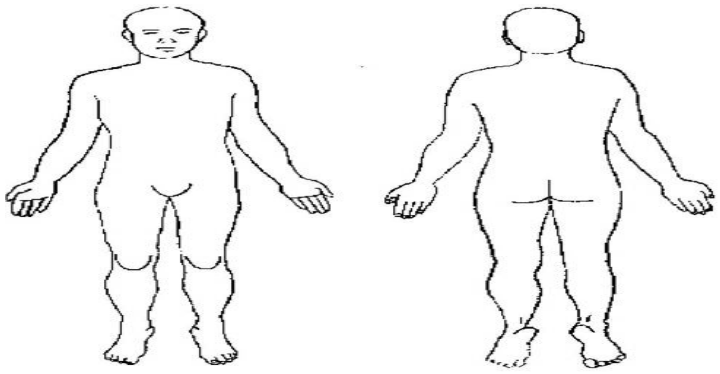
5. Do you have any particular goals in mind for this massage session?

   If yes, please explain _____

6. What pressure do you prefer? Please Circle: Light Firm Deep

Circle any specific areas you would like the massage therapist to **concentrate** on during the session:

Use an **X** over any areas you would like your therapist to **avoid**:



Medical History **In order to plan a massage session that is safe and effective, I need some general information about your medical history.**

5. Are you currently under medical supervision? Yes No
   If yes, please explain _____
6. Are you currently taking any medication? Yes No
   If yes, please list _____
7. Please check any condition listed below that applies to you:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) sprains/strains
( ) current fever
( ) swollen glands
( ) allergies/sensitivity
( ) heart condition

( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) atherosclerosis
( ) Fibromyalgia
( ) phlebitis
( ) deep vein thrombosis/blood clots
( ) joint disorder
( ) rheumatoid arthritis
( ) osteoarthritis
( ) tendonitis
( ) osteoporosis

( ) headaches/migraines
( ) cancer
( ) diabetes
( ) epilepsy
( ) decreased sensation
( ) TMJD
( ) carpal tunnel syndrome
( ) tennis elbow
( ) Plantar fasciitis
( ) Sciatica/sciatic pain
( ) pregnancy
If yes, how many months?
_____

Please explain:
_____
_____

8. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

_____

Clients under the age of 16 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, _____ (print name) understand that the massage 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 therapist 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 therapists 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 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 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.
Disclaimer of Liability: Absolute Body Balance only employs professional massage therapists who comply with state, city and/or local licensing requirements. It is your responsibility to notify your therapist and clinic of any pre-existing conditions, limitations, or sensitivities that may have an effect on your therapy session as well as any discomfort felt during your session. You understand and voluntarily accept any risks associated with your treatment and/or any use of the clinic's facilities. Except where prohibited by law, you agree that Absolute Body Balance will not be liable for any injury, including, without limitation, personal, bodily or mental injury, economic loss, or any damage to you resulting from negligence, other acts of the clinic, anyone on the clinic's behalf, or anyone using the services of the facilities of the clinic.

Signature of client _____ Date _____
Signature of Massage Therapist _____ Date _____