Thank you for choosing to use *A Time To Heal Massage Therapy* to meet your body's needs.

Please fill out the following information to give your therapist some background to work with.

*Required fields

Was this a referral? From whom?

_____

*Name: _____ Date: _____

*Address:_____

*Birthday:_____*Phone_____

*Email:_____

Occupation:_____

*Emergency contact/phone:_____

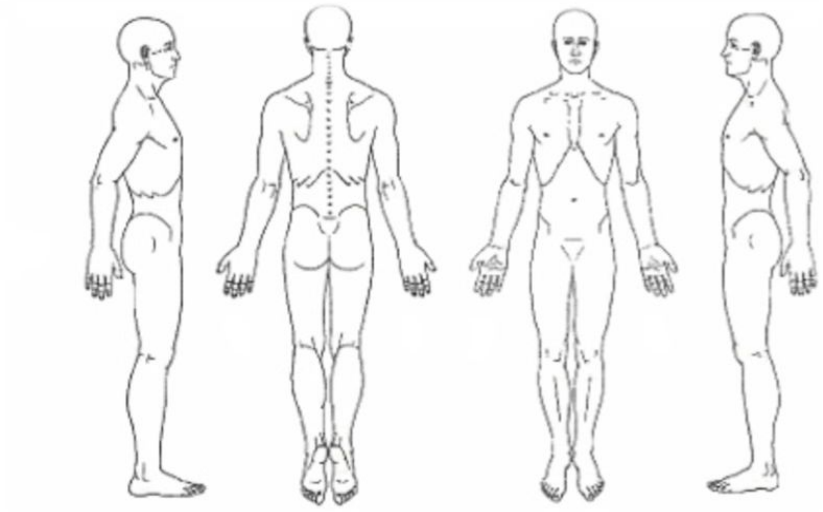
*Have you ever been in the military, fire department, or law enforcement? Yes No

What do you do in your spare time/what are your hobbies?

What do you do for stress relief/stress management?

What are your goals for incorporating massage into your life?

*Please mark on the drawings where you are feeling any discomfort:



*Now for a little medical history...
Please check any condition you have (or for surgeries/serious conditions, you have had):

Musculo-Skeletal __Headaches __Migraines __Back Pain __Shoulder Pain __Neck Pain __Tendonitis __Bursitis __Jaw Pain/TMJ __Strain/sprain __Osteoporosis __Scoliosis __Arthritis (osteo/rheumatoid) __Joint Pain __Other_____ Reproductive __Pregnancy Current #of weeks_____ __PMS __Menopause __Endometriosis __Hysterectomy __Prostate Problems __Other_____	Skin __Rashes __Athlete's Foot __Allergies __Warts __Acne __Psoriasis __Eczema __Cosmetic Surgery __Other_____ Nervous System __Numbness/Tingling __Fatigue __Chronic Pain __Epilepsy __Multiple Sclerosis __Parkinson's Disease __Other_____ Digestive __Indigestion __Constipation __Diverticulitis __Irritable Bowel Syndr. __Colitis __Crohn's Disease __Other	Circulatory/Respiratory __Cold Feet/ Hands __Varicose Veins __Blood Clots __Stroke __Heart Attack __Heart Disease __Lymph edema __High Blood Pressure __Low Blood Pressure __Sinus Problems __Asthma __COPD __Other_____ Other __Depression __Confusion __Surgery_____ __Alcohol Use_____ __Caffeine Use_____ __Nicotine Use_____ __Hearing Impaired __Visually Impaired __Fibromyalgia __Cancer _____ __Diabetes Type I/Type II

Do you wear contacts? Yes_____ No_____
Are you sensitive to heat/cold? Yes_____No_____
*Do you have any allergies? Yes_____ No_____
If so, what are they?
*Are you pregnant or trying to become pregnant? Yes_____No_____
*Have you had an injury or surgery that still affects you? Yes_____ No_____
Please explain...

*Are you on any medication? Yes____ No_____
Please list along with any side effects you are experiencing:

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 understand that I will be draped with a sheet and/or large blanket for the entire massage treatment. The draping will be adjusted to uncover only the area of the body that is receiving massage. At no time will a treatment be given with insufficient draping to any client, male or female.

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 of which I am aware.

If I am under 17 years of age, I need to have a consent form signed by a legal guardian in order to receive therapeutic massage.

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.

I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate cessation of the session, and I will be liable for the payment of the full scheduled appointment.

I have read and agree to the terms of the cancellation policy.

*Name_____*Date_____
*Signature_____