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.

Was this a referral? From whom?

_____

Name: _____ Date: _____

Address:_____

Birthday:_____Phone_____

Cell phone carrier (if applicable-i.e. Sprint, Verizon, etc.)_____

Email:_____

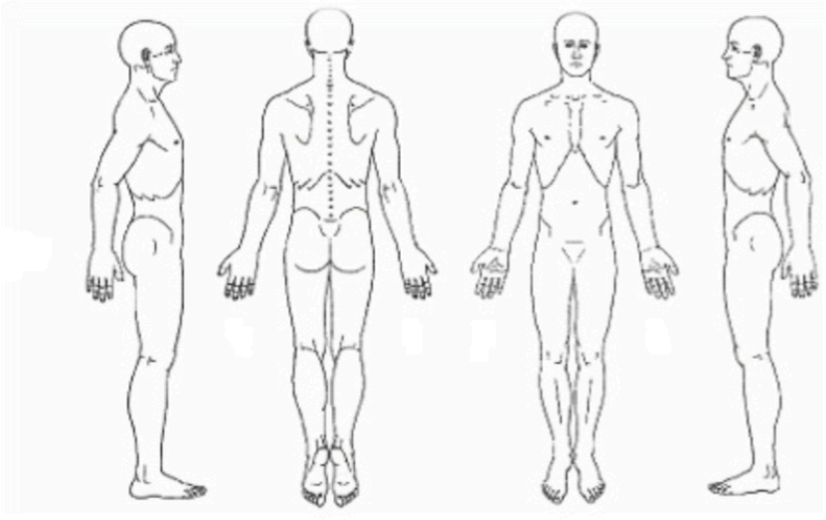
Occupation:_____

Emergency contact/phone:_____

Have you ever been in the military, fire department (not auxiliary), or law enforcement?

**Yes No**

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



Medical History. Please check any condition you have:

| Musculo-Skeletal | Skin | Circulatory/Respiratory |
|---|---|---|
| ___Headaches | ___Rashes | ___Cold Feet/ Hands |
| ___Migraines | ___Athlete's Foot | ___Varicose Veins |
| ___Back Pain | ___Allergies | ___Blood Clots |
| ___Shoulder Pain | ___Warts | ___Stroke |
| ___Neck Pain | ___Acne | ___Heart Attack |
| ___Disc issues (detail below*) | ___Psoriasis | ___Heart Disease |
| ___Tendonitis | ___Eczema | ___Lymph edema |
| ___Bursitis | ___Cosmetic Surgery | ___High Blood Pressure |
| ___Jaw Pain/TMJ | ___Other_____ | ___Low Blood Pressure |
| ___Strain/sprain | | ___Sinus Problems |
| ___Osteoporosis | Digestive | ___Asthma |
| ___Scoliosis | ___Indigestion | ___COPD |
| ___Arthritis (osteo/rheumatoid) | ___Constipation | ___Other_____ |
| ___Joint Pain | ___Diverticulitis | |
| ___Other_____ | ___Irritable Bowel Syndr. | Other |
| | ___Colitis | ___Depression |
| Nervous System | ___Crohn's Disease | ___Surgery_____ |
| ___Numbness/Tingling | ___Other | ___Hearing Impaired |
| ___Fatigue | | ___Visually Impaired |
| ___Chronic Pain | Reproductive | ___Fibromyalgia |
| ___Epilepsy | ___PMS | ___Cancer _____ |
| ___Multiple Sclerosis | ___Menopause | ___Diabetes Type I/Type II |
| ___Parkinson's Disease | ___Endometriosis | |
| ___Other_____ | ___Hysterectomy | |
| | ___Prostate Problems | |
| | ___Other_____ | |

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

Do you have any allergies? Yes_____ No_____If so, what are they?
Are you pregnant or trying to become pregnant? Yes_____No_____# of weeks_____
*Have you had an injury or surgery that still affects you? Yes_____ No_____
Please explain…

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.

No sexual activity is permitted while on the business premises.

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

*Name_____*Date_____
*Signature_____