

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: _____

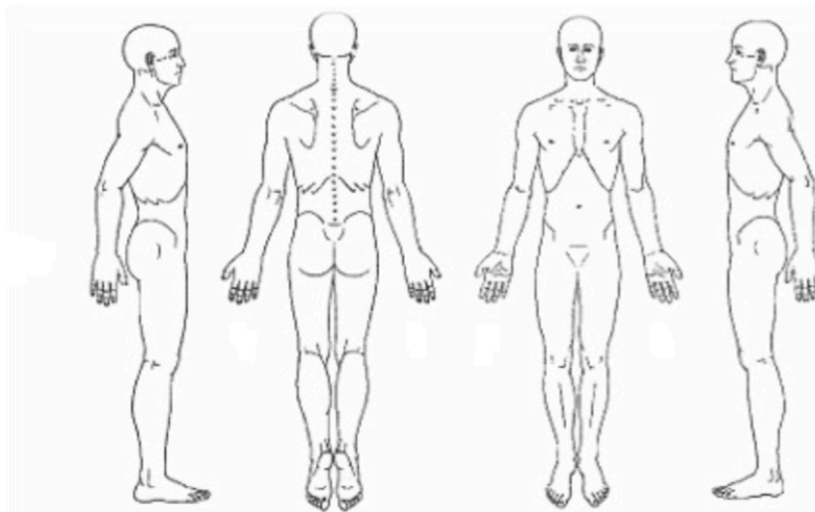
Occupation: _____

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:

<u>Musculo-Skeletal</u> <input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Back Pain <input type="checkbox"/> Shoulder Pain <input type="checkbox"/> Neck Pain <input type="checkbox"/> Disc issues (detail below*) <input type="checkbox"/> Tendonitis <input type="checkbox"/> Bursitis <input type="checkbox"/> Jaw Pain/TMJ <input type="checkbox"/> Strain/sprain <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Scoliosis <input type="checkbox"/> Arthritis (osteo/rheumatoid) <input type="checkbox"/> Joint Pain <input type="checkbox"/> Other _____ <u>Nervous System</u> <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Fatigue <input type="checkbox"/> Chronic Pain <input type="checkbox"/> Epilepsy <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Other _____	<u>Skin</u> <input type="checkbox"/> Rashes <input type="checkbox"/> Athlete's Foot <input type="checkbox"/> Allergies <input type="checkbox"/> Warts <input type="checkbox"/> Acne <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema <input type="checkbox"/> Cosmetic Surgery <input type="checkbox"/> Other _____ <u>Digestive</u> <input type="checkbox"/> Indigestion <input type="checkbox"/> Constipation <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Irritable Bowel Syndr. <input type="checkbox"/> Colitis <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Other _____ <u>Reproductive</u> <input type="checkbox"/> PMS <input type="checkbox"/> Menopause <input type="checkbox"/> Endometriosis <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Other _____	<u>Circulatory/Respiratory</u> <input type="checkbox"/> Cold Feet/ Hands <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Blood Clots <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Disease <input type="checkbox"/> Lymph edema <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Other _____ <u>Other</u> <input type="checkbox"/> Depression <input type="checkbox"/> Surgery _____ <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Diabetes Type I/Type II
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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.

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

*Name_____ *Date_____

*Signature_____