MASSAGE THERAPY - Client Health History

Name: _____ Date of Birth: _____

Address: _____

City: _____State: _____ Zip: _____

Home Telephone: _____ Cell: _____ Work: _____

Male ____ Female ____ Emergency Contact: _____ Telephone: _____

Email Address: _____

Referred By: _____

Please take a moment to carefully read the following information. If you have a specific medical condition or symptoms, massage and/or bodywork may be contraindicated. In some cases, a referral from your primary care provider may be required prior to services being provided. Please indicate "yes" or "no" to the following:

Yes	No	Have you ever experienced a professional massage or bodywork session? If			
Yes	No	Frequent stress	Yes	No	Numbness or tingling anywhere
Yes	No	Frequent headaches	Yes	No	Stabbing pain anywhere
Yes	No	Back Pain	Yes	No	Sensitive to touch or pressure in
Yes	No	Diabetes	Yes	No	Do you bruise easily?
Yes	No	Arthritis	Yes	No	Are you wearing contact lenses?
Yes	No	High blood pressure	Yes	No	Are you wearing dentures?
Yes	No	Blood pressure medication	Yes	No	Are you feeling well today?
Yes	No	Cardiac or circulatory problems	Yes	No	Do you have tension or soreness
Yes	No	Blood-thinning medication - please list:			Please specify:
Yes	No	Epilepsy or seizures			
Yes	No	Joint swelling	Yes	No	Have you ever had surgery?
Yes	No	Varicose veins			
Yes	No	Contagious diseases			
Yes	No	Osteoporosis	Yes	No	Do you have any other medical conditions, or are you taking any
Yes	No	Allergies			medications we should be aware
Yes	No	Injuries or accidents in the past two years			
Yes	No	Broken bones in the past two years			
Yes	No	Females Only: Pregnancy (# of weeks)			

I understand that the massage/bodywork 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 comfort level. I further understand that massage or bodywork 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/bodywork practitioners 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 this session should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I

MASSAGE THERAPY - Client Health History

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 be no 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 that I will be liable for payment of the scheduled appointment. All appointments are pre-paid by check, cash or major credit card. ***A 24 hour cancellation notice is required*** *to avoid being charged for a scheduled session.*

All Massage Packages are non refundable, but transferable, and Expire 6 months from the date of purchase.

Comments/Explanations: _____

_____

Print Name: _____ Client Signature: _____

Date: _____

The Pilates Experience
Karen A. Irish - Owner/Director
503 Duane St., Suite A - Glen Ellyn, IL 60137
www.pilatesexp.com - pilatesexp@aol.com
630-605-3266