

# Intuitive Touch – Therapeutic Massage and Bodywork – Client Information

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

E-Mail: \_\_\_\_\_  Male  Female

Occupation: \_\_\_\_\_ Referred by: \_\_\_\_\_

In case of Emergency: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

**Do I have your permission to contact your Physician if the need arises?**  Yes  No

Have you ever experienced a professional massage or bodywork session?  Yes  No How recently? \_\_\_\_\_

What kind of pressure do you prefer?  Light  Medium  Firm

Do you experience any difficulty lying either on your front or your back?  Yes  No

Any specific areas of tension or soreness? \_\_\_\_\_

**Please take a moment to carefully check the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your Physician may be required prior to service being provided.**

## Medical History: (Check all that apply)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> AIDS                         | <input type="checkbox"/> Fibromyalgia                        | <input type="checkbox"/> Osteoporosis               |
| <input type="checkbox"/> Allergies _____              | <input type="checkbox"/> Fibrositis                          | <input type="checkbox"/> Pain medication            |
| <input type="checkbox"/> Arteriosclerosis             | <input type="checkbox"/> Headaches                           | <input type="checkbox"/> Phlebitis                  |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Heart disease                       | <input type="checkbox"/> PMS / painful menstruation |
| <input type="checkbox"/> Back pain                    | <input type="checkbox"/> Herniated disc                      | <input type="checkbox"/> Rheumatoid Arthritis       |
| <input type="checkbox"/> Blood clots / Blood thinners | <input type="checkbox"/> High blood pressure                 | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Bruise easily                | <input type="checkbox"/> Blood pressure medication           | <input type="checkbox"/> Skin sensitivity           |
| <input type="checkbox"/> Cancer / Malignancy          | <input type="checkbox"/> Inflammation                        | <input type="checkbox"/> Sleep problems             |
| <input type="checkbox"/> Carpal tunnel syndrome       | <input type="checkbox"/> Inner ear problem                   | <input type="checkbox"/> Stress                     |
| <input type="checkbox"/> Contact Lenses               | <input type="checkbox"/> Joint pain or replacement           | <input type="checkbox"/> Swelling                   |
| <input type="checkbox"/> Contagious diseases          | <input type="checkbox"/> Joint swelling                      | <input type="checkbox"/> Tendinitis / bursitis      |
| <input type="checkbox"/> Dentures                     | <input type="checkbox"/> Lupus                               | <input type="checkbox"/> TMJ syndrome               |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Nausea                              | <input type="checkbox"/> Varicose veins             |
| <input type="checkbox"/> Epilepsy or seizures         | <input type="checkbox"/> Numbness / tingling / stabbing pain | <input type="checkbox"/> Other Medications _____    |
| <input type="checkbox"/> Fainting spells              | <input type="checkbox"/> Osteoarthritis                      | _____   |

Are you Pregnant or trying to get pregnant?  Yes  No

Recent Surgery / Injury / Broken bones \_\_\_\_\_

List any other Medical conditions or specific symptoms \_\_\_\_\_

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 level of comfort. 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 of which I am aware. 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 the session given should be construed as such. Because massage/ bodywork 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 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 I will be liable for payment of the scheduled appointment.

Client Signature

Date