Movement for Life Massage, LLC

Massage Information & History

Personal Information

Name ______________________ email ______________________

Phone (Cell) ______________________ Phone (Home) ______________________

Address ______________________

City ______________________ State ________ Zip ________

Date of Birth ______________________ Occupation ______________________

Emergency Contact ______________________ Phone ______________________

Email______________________

How did you hear about us? ______________________

The following information will be used to help plan safe and effective massage sessions.
Please answer the questions to the best of your knowledge.
Date of Initial Visit ______________________

1. Have you had a professional massage before? Yes No
   If yes, how often do you receive massage therapy? ______________________
2. Do you have any difficulty lying on your front, back, or side? Yes No
   If yes, please explain ______________________
3. Do you have any allergies to oils, lotions, or ointments? Yes No
   If yes, please explain ______________________
4. Do you have sensitive skin? Yes No
5. Are you wearing contact lenses dentures a hearing aid ?
6. Do you sit for long hours at a workstation, computer, or driving? Yes No
   If yes, please describe ______________________
7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
   If yes, please describe ______________________
8. Do you experience stress in your work, family, or other aspect of your life? Yes No
   If yes, how do you think it has affected your health?
   Muscle tension anxiety insomnia irritability other ______________________
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?
   Yes No
   If yes, please identify ______________________
10. Do you have any particular goals in mind for this massage session? Yes No
    If yes, please explain ______________________

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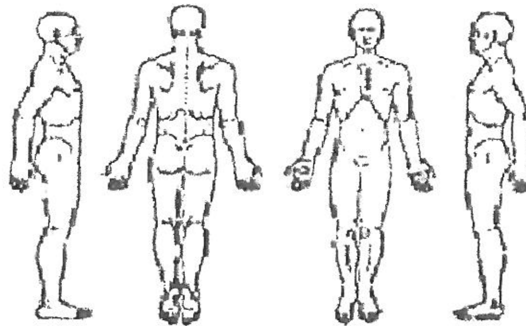

Circle any specific areas you would like the massage therapist to concentrate on during the session

Medical History

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

11. Are you currently under medical supervision? Yes No
    If yes, please explain ___
12. Do you see a chiropractor? Yes No If yes, how often? ___
13. Are you currently taking any medication? Yes No
    If yes, please list ___
14. Please check any condition listed below that applies to you:

contagious skin condition	phlebitis
open sores or wounds	deep vein thrombosis/blood clots
easy bruising	joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
recent accident of injury	osteoporosis
recent surgery	epilepsy
artificial joint	headaches/migraines
sprains/strains	cancer
current fever	diabetes
swollen glands	decreased sensation
allergies/sensitivity	back/neck problems
heart condition	Fibromyalgia
high or low blood pressure	TMJ
circulatory disorder	carpal tunnel syndrome
varicose veins	tennis elbow
atherosclerosis	pregnancy if yes, how many months?

Please explain any condition that you have marked above ___

___

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? ___

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Draping will be used during the session – only the area being worked on will be uncovered.
Informed written consent must be provided by parent or legal guardian for any client under the age 17.

Essential Oils Informed Consent

The use of doTerra Essential Oils promotes immunological and psychological benefits. By signing this release, you agree that Movement for Life Massage, LLC/BHHWC is not, under any circumstance, responsible for any allergic response or negative side effects that may have been caused from your essential oils treatment.

Signature of client ___ Date ___

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I, ________________________________(print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this massage session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. 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 termination of the session. I also understand that the License Massage Therapy reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

Signature of client ____ Date ________________

Consent of Treatment of a Minor: My signature below herby authorizes a Certified Massage Therapist to administer massage, bodywork or somatic therapy techniques to my child or dependent, as they deem necessary.
Signature of Parent or Guardian ____________________________________ Date ________________

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