

CLIENT INFORMATION - MESSAGE RELEASE FORM

Personal Information

Name: _____ Date: _____ Date of Birth: _____
 Address: _____ City: _____ State _____ Zip _____
 Phone: _____ Occupation: _____ Email: _____
 How did you hear about us? (*online search, gift certificate, social media, name of referrer - so we can thank them, other?*)

Health History

Please list any conditions that you have or are being treated for:

- | | |
|--|--|
| <input type="checkbox"/> Allergy to Latex | <input type="checkbox"/> Allergic to Perfumes |
| <input type="checkbox"/> Uncontrolled blood pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Controlled High Blood Pressure | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Skin Sensitivity | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Tinnitus (ringing in the ears) |
| <input type="checkbox"/> TMJ Dysfunction | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Bunions | <input type="checkbox"/> Neurological Disorder (specify) |
| <input type="checkbox"/> Chronic Muscle Pain | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Acute Muscle Pain/Spasm | <input type="checkbox"/> Anatomically Short Leg |
| <input type="checkbox"/> Spinal Subluxation (chiropractic) | <input type="checkbox"/> Fused Vertebrae (specify) |
| <input type="checkbox"/> Other (please specify) _____ | |

List any musculoskeletal surgeries and severe injuries you have had: _____

List any other surgeries and severe injuries you have had: _____

List all medications you are currently taking and what you are taking them for: _____

Why are you here for a massage today?

- | | |
|---|--|
| <input type="checkbox"/> Just to relax | <input type="checkbox"/> Chronic or Acute Pain/Spasms |
| <input type="checkbox"/> Referral from a friend | <input type="checkbox"/> Doctor or Chiropractic Referral |
| <input type="checkbox"/> Injury Prevention (increase range of motion, joint mobility) | <input type="checkbox"/> Other? _____ |

What areas of your body need specific attention? _____

What did you like or dislike about previous massages? _____

Are you comfortable letting your therapist know if you have concerns about pressure, temperature or anything else during your session? _____ Do you have any specific requests for our session? (ex. Music, temp, etc.) _____

Please take a moment to carefully read the following information and sign where indicated:

Massage/bodywork is not a substitute for medical examinations, diagnosis, or treatments. I should see a physician for any physical or mental ailment. Massage therapists are not qualified to diagnose, prescribe, or treat any physical or mental illness, and nothing said in the session(s) should be construed as such. I have stated all known medical conditions. 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 forget to do so.

Aches Away may request credit card information to hold appointments in situations where clients have missed appointments and do not call to cancel within 2 hours,

Signed: _____