Therapy n Motions

Massage Consultation

Personal Data

Name_____ Phone(day)_____ Phone(eve)_____
Address:_____City_____State____Zip_____
Date of Birth:_____Male___ Female___Occupation_____
Primary Health Care Provider_____Phone_____
Emergency Contact_____Phone_____

Massage History/Treatment Information

Have you ever received a professional massage?_____Date of last massage_____
Type of massage experienced: Swedish____ Deep Tissue_____Other_____
What are your Goals/Expectations for this therapy session?_____
_____
Prioritize the areas of your body that you would prefer to be massaged or areas that need special attention_____
_____
Are there any areas of your body that you prefer not be massaged?_____
_____
Are you currently seeing a medical practitioner?_____If yes, please explain_____
_____
List current medications, including aspirin,ibuprofen, etc._____
_____
Have you consumed alcohol in the past 24 hours?_____
Do you have any allergies?_____
Do you have a history of the following? (if yes please circle)

Accident	**Sprains**	**Mastectomy**	**Sinus Trouble**
Neck Pain	**Seizures**	**Abdominal Pain**	**Nervous Tension**
Whiplash	**Arthritis**	**Bursitis**	**Gout**
Headaches	**Upper Back Pain**	**Lower Back Pain**	**Mid Back Pain**
Joint Ache	**Broken Bones**	**Sciatica**	**Wear Contacts**
Scoliosis	**Diabetes**	**Varicose Veins**	**High Blood Pressure**
Stroke	**Heart Attack**	**Cancer**	**Colitis**
HIV	**Fibromyalgia**	**Carpal tunnel**	**Varicose Veins**

Please list any other past history_____
_____
Have you had any surgeries?(include year & treatment received)_____
_____
_____

Do you have any of the following today?

Sunburn	**Open Cuts, Brusies, Burns**	**Inflammation**
Irriatated Skin Rash	**Severe Pain**	**Poison Ivy**
Headache	**Cold/Flu**	

Please list any other discomforts_____
_____

How did you hear of Therapy N Motions? _____

Please read the following and sign below:

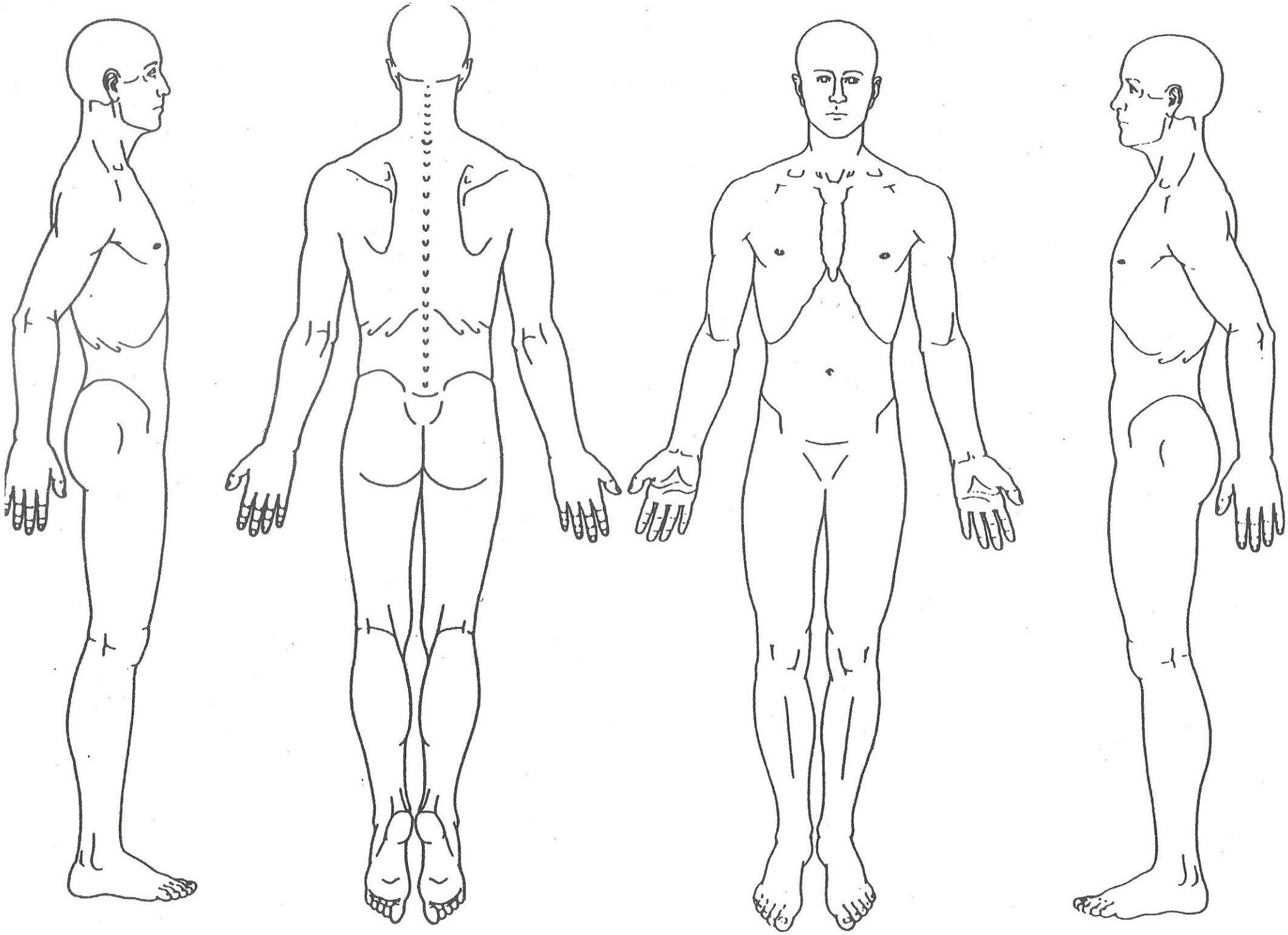
- **I understand that this massage is not a replacement for medical care and that no diagnosis will be made.**
- **I understand that this is a NON-SEXUAL massage therapy session.**
- **Conservative Draping will be used at all times during the session.**
- **As the client you have the right to terminate the session if you are uncomfortable in any way. As the therapist I have the right to terminate the session if I am uncomfortable in any way.**

By signing this I confirm that all of the information I have provided on this form is true and accurate to the best of my knowledge. I am aware that failure to alert the therapist to any medical conditions could result in adverse effects. I hereby voluntarily assume all such risks of loss, damage, or injury. I also confirm that I have read, understand and agree to the above notices.

_____ _____
Client Signature Date

I agree to the above notices and I furthermore agree as a therapist to abide by the client's wishes and restrictions as long as they are within my scope of practice and my personal code of professional ethics.

_____ _____
Therapist Signature Date



Name: _____ Date:_____