

RECLAIMING
Healing Arts

Client Profile

Name

Occupation

Date of Birth

Address

Email

Would you like to receive my monthly e-newsletter with event updates and wellness tips? [YES NO]

Phone

What life challenge/event/daily activity causes the most stress?

Where do you feel this in your body?

Medical/Heath issues [please list all diagnosis,allergies, or areas of concern] :

Injuries [acute/chronic]:

Medication :

Describe your current fitness level and activities [include frequency/duration]:

Name of primary care physician/phone # :

Do you see other health professionals [Therapist, Counselor, Massage Therapist, etc] ?

When was your last massage?

Are there any areas you do NOT want worked on?

Are there any areas that you would like to focus on?

What type of pressure do you prefer? [light, medium, firm, deep]

What are you hoping to get out of, and goals for, receiving massage therapy?

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 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 a 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 my appointment time is scheduled specifically for me, and that time is reserved. Should I need to cancel or reschedule, I will give 24 hour notice, or will be financially responsible for the fee of the appointment missed. I hereby authorize records to be released to my medical provider.

Client X _____ Date _____

Jamie Smith X _____ Date _____