Client Information

Name: _____

Address: _____

Phone: (H) _____ (C) _____ (W) _____

E-Mail: _____

Confirm Appointments by: Phone Text E-mail

Date of Birth: ____/____/____

Occupation: _____

Referred by: _____

In case of Emergency: _____ Phone: _____

Medical Information

Do you have or have you had a history of any of the following?

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Conditions
- ☐ Cancer
- ☐ Cardiac Problems
- ☐ Circulatory Problems
- ☐ Constipation
- ☐ Diabetes
- ☐ Digestive Problems
- ☐ Epilepsy
- ☐ Fatigue
- ☐ Fibromyalgia
- ☐ Headaches
- ☐ Joint Pain
- ☐ High Blood Pressure
- ☐ Insomnia
- ☐ Osteoporosis
- ☐ Sinusitis
- ☐ Skin Conditions
- ☐ Varicose Veins

Do you have any medical conditions not mentioned here? _____

_____

Have you had any recent injuries, surgeries or illnesses? _____

_____

Are you currently taking any medications? _____

_____

Do you have chronic tension or soreness in any specific areas? _____

_____

Are you sensitive to pressure or ticklish in any area? _____

Are you currently pregnant? _____

What do you hope to get from our sessions? _____

_____

What are some of your personal goals? _____

_____

Is there anything else you would like me to know? _____

Release Form

I understand that the massage, polarity and craniosacral therapy that I receive is provided for the basic purpose of relaxation, stress reduction, 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 techniques may be adjusted to my comfort level.

I further understand that neither massage, polarity, nor craniosacral therapy should 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 medical or physical ailment that I am aware of.

Because bodywork is contraindicated under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all intake questions honestly. I agree to keep my practitioner updated as to any changes in my medical profile, and I understand that there will be no liability on the practitioner's part should I forget to do so.

It is also understood 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 for the full scheduled appointment.

Should I need to cancel future sessions, I agree to give my practitioner 48 hours notice or I will be financially responsible for the session time.

Signed: _____
Date: ____/____/____

Guardian (if client is under 18): _____
Date: ____/____/____