Christine's Royal Treatment
Therapeutic Massage & Spa Services
Client Information

Date:__/____/____

First Name:_____Last Name:_____

Date of Birth:____/__/_____

Address:_____Appt #_____City:_____

State:_____Zip:_____Phone Numbers: H#:_____C#:_____

Email Address:_____

Occupation:_____Phone#:_____Employer:_____

Emergency contact:_____Phone #:_____

How did you hear about Christine's Royal Treatment?_____

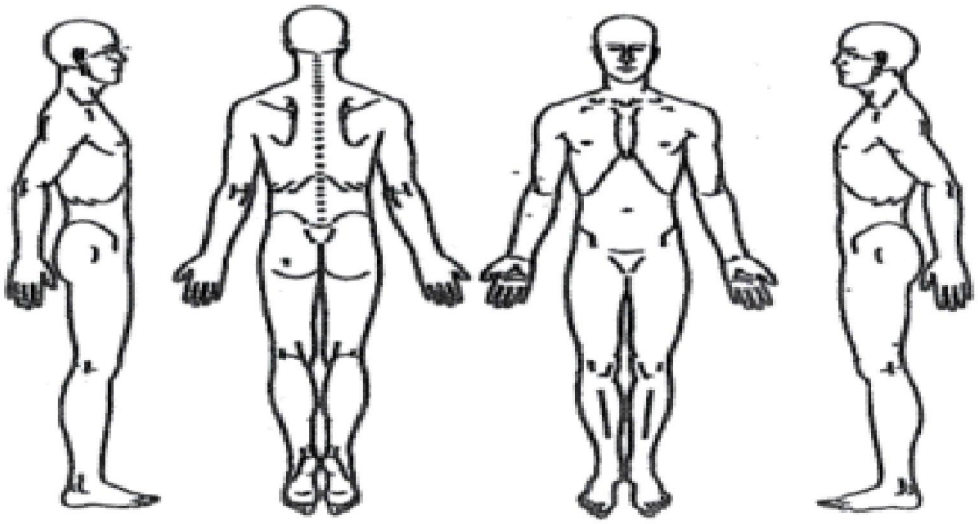
Why have you come for a therapeutic massage?_____

Have you had a massage before? Yes_____No_____.

If Yes how long since your last massage?_____

On a scale from 1 -10 What is your current level of Pain? 1 = No pain 10 = Maximum pain


1 2 3 4 5 6 7 8 9 10

Mark with an X where you feel stress or pain.

Do you exercise regularly? Yes_____No_____

If Yes what type of exercise?_____

How offen do you exercise?_____

Medical Information

Are you currently under medical supervision? YES___ NO_____

Name of Physician:_____Contact #:_____

Are you taking prescription drugs?: YES___ NO_____

Do you take blood thinning drugs? YES___ NO_____

Were you referred by another Health care professional? YES_____ NO_____

Referred by:_____ Profession:_____

Contact #:_____

Do you currently have any acute injuries that have occurred in the past 72 hours?

YES_____ NO_____

If yes, please explain:_____

Check all that apply	Past	Present
☐ Allergies		
☐ Arthritis		
☐ Back Injuries/Problems		
☐ Blood Clots		
☐ Bruise Easily		
☐ Carpel Tunnel Syndrome		
☐ Circulation Problems		
☐ Contact Lens		
☐ Cancer		
☐ Digestive Problems		
☐ Diabetes		
☐ Fibromyalgia		
☐ Headaches		
☐ Heart Disease		
☐ Hypertension		
☐ Hypotension		
☐ Infectious Disease		
☐ Inflammatory Disease		

	Past	Present
☐ Joint Injuries/Problems		
☐ Kidney Disease		
☐ Liver Disease		
☐ Lung Disease		
☐ Numbness/ Tingling		
☐ Paralysis		
☐ Pregnant		
☐ Previous Trauma		
☐ Sciatica		
☐ Seizures/Epilepsy		
☐ Sinusitis		
☐ Skin Problems		
☐ Stoma/Colostomy/Ileostomy		
☐ Stroke/ CVA		
☐ Surgeries		
☐ TMJ (Jaw pain)		
☐ Varicose Veins/ Thrombophlebitis		

Please briefly explain all checked problems/ issues:_____

_____

_____

_____

_____

_____

Client Signature: _____ **Date:** / /

Therapist Signature: _____ **Date:** / /

Do you take regular analgesic drugs?(Pain killers) YES_____ NO_____

Do you take regular therapeutic narcotic drugs? YES_____ NO_____

Have you eaten within the past 2 hours? YES_____ NO_____

Have you drank alcohol today? YES _____ NO_____

Do you have any other condition or relevant information you think the therapist should be aware of? If so please give details_____

_____

Informed Consent

* The above information is accurate to the best of my knowledge.

* I understand that all massage therapy given by _____LMT, is for the basic purpose of soft tissue manipulation, stress reduction, relief from muscular tension or spasm, or for increased circulation and energy flow.

* As discussed and agreed the following massage technique(s) will be used during the session :_____

_____

* Specific care or avoidance of the following areas will be practiced due to medical or personal reasons:

_____

* If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes maybe adjusted to my level of comfort or I may ask the terapist to discontinue the session at any point.

* I understand that I will be draped and only the areas being massaged will be exposed as necessary, and that the therapist will NOT touch or expose the genitalia.

* Breast massage will only be performed with written consent for female clients.

* I further understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment and that I should seek a physician, chiropractor or other qualified medical specialist for any condition that requires treatment.

* I understand that massage therapists do not perform spinal or skeletal adjustments, diagnose illness or disease, or any other physical or mental disorders, prescribe pharmaceuticals for or treat any physical imbalances, and that anything said during the session(s) should not be construed as such.

* If I have a medical condition or specific symptom for which massage maybe contraindicated (should not be give), a referral from my primary care provider maybe required before massage can be given. This referral maybe required as massage is not appropriate in all circumstances.

* I agree to update the massage therapist in regard to changes in my health and understand that there shall be no liability on the therapist's part should I forget to do so.

* In consideration for this, I do hereby discharge this therapist, all affiliates, directors, officers and employees from any and all causes of action, suits, debts, claims and any kind whatsoever arising from or by reason of any injuries which might occur as a result of having therapeutic massage performed. By signing below, I acknowledge that I have read and understand the meaning of this release.

* I also understand that any inappropriate comments or actions of a sexual nature will not be tolerated and will result in the termination of the session with immediate effect and I will be asked leave the premises.

I have read and understand the above consent and therefore I freely give my permission to be massaged.

Signature:_____Date:_____/_____/_____

Signature of Parent or Legal Guardian:_____(if under 18yrs of age)

Therapist's signature:_____Date:_____/_____/_____