**Massage Client Information**

**Harmonious Balance Spa Leslie Dudley, LMT**

Name:­­­ D.O.B.:

Address: City: State:

Zip: Home Phone: Cell Phone:

Place of Business: Occupation:

Referred By: Email:

1. Have you ever received a professional massage?:

2. Reasons for therapeutic massage (major complaint):

3. Is there anything that makes your condition worse?:

4. Are you currently being treated by any of the following?

( ) Medical Doctor Name:

( ) Chiropractor Name:

( ) Psychiatrist Name:

5. Please list any present medications used and their purpose:

Med Purpose

Med Purpose

Med Purpose

6. Have you had any surgeries? Explain

7. Emergency Contact: Name: Phone:

8. The pressure of your massage should be: ( ) Deep ( ) Moderate ( ) Light/Nurturing

9. Please check all that apply:

( ) Headaches ( ) Joint Stiffness/Swelling ( ) Spasms/Cramps ( ) Arm/Hand Pain

( ) Back/Hip Pain ( ) Shoulder/Neck Pain ( ) Leg/Foot Pain ( ) Lymphedema

( ) Jaw Pain/TMJ ( ) Arthritis ( ) Osteoporosis ( ) Dizziness

( ) Poor Circulation ( ) Anemia ( ) Varicose Veins ( ) Warts

( ) High Blood Pressure ( ) Shortness of Breath ( ) Fatigue ( ) Fibromyalgia

( ) Low Blood Pressure ( ) Rashes ( ) Cancer ( ) Menopause

( ) Endometriosis ( ) Phlebitis ( ) Diabetes ( ) Pregnancy

( ) Sleep disorder ( ) Survivor of Abuse ( ) Intestinal Disorder

( ) Infectious Disease (please list):

( )Other congenital or acquired disabilities(please list):

 I confirm (to the best of my knowledge) that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment. I will not hold the establishment or the massage therapist responsible for any damages to myself physically or to my personal property. Any possible damages that may occur are void by signing this release form.

Signature: Date: