BODYTHYME
Massage

# Confidential Client Information and Health History

Full name_____ birth date_____

Phone (cell)_____ (home)_____ (work)_____

Email_____

Address_____ city_____ state_____ zip_____

Employer_____ occupation_____

Emergency contact_____ phone_____ relationship _____

How did you hear about Body Thyme?

◯ family/Friends ◯ Website ◯ Internet ◯ Other

Referred by_____

Is this your first massage?_____ If no, how frequently do you get a massage?_____

Reason for visit:_____

Describe any surgeries, hospitalizations, accidents or injuries you have had:

Less than 5 years ago:_____

More than 5 years ago:_____

Do you have any history of chronic pain?_____

Are you taking medication or supplements?_____

Are there any significant changes in your health status that your massage therapist should know?

_____

What type and frequency of exercise do you do?_____

Are you right or left hand dominant? ◯ Right ◯ Left

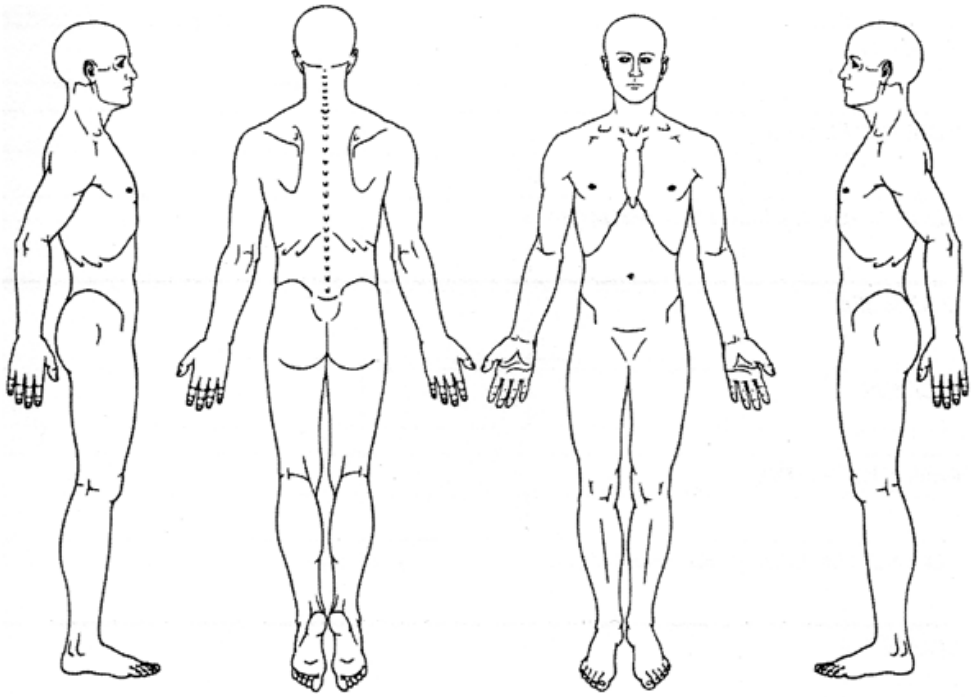
Do you wear contact lens? ◯ Yes ◯ No

Do you have any allergies or aversions to the following?

Lotion/Oil ◯ Laundry soap ◯ Essential Oils ◯ Plants ◯ Nuts ◯ None ◯

OVER ⟶

Please indicate where you experience pain on the drawings provided.



Please check any of the following conditions below that currently affect you or that you have experienced in the last 5 years.

____ Fibromyalgia
____ Spasms/Cramps
____ Sprains/Strains
____ Osteoporosis
____ Postural Deviations
____ Gout
____ Osteoarthritis
____ Rheumatoid Arthritis
____ TMJ Dysfunction
____ Cysts
____ Bursitis
____ Plantars Fascitis
____ Tendonitis
____ Torticollis
____ Whiplash Syndrome
____ Carpal Tunnel Syndrome
____ Sciatica
____ Thoracic Outlet Syndrome
____ Headache
____ Leg Pain
____ Arm Pain/Shoulder Pain
____ Low Back Pain
____ Mid Back Pain
____ Hip Pain
____ Other

## Please read below and provide your signature and date to show that you understand our cancelation policy, and agree to all terms and conditions. Please note that payment is required at the time of service.

◯ The information on this form is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications, or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental, or emotional changes that occur with my health.

◯ I understand that there is no implied or stated guarantee of success or effectiveness for bodywork/massage sessions. It is my choice to receive bodywork/massage and I give my consent for bodywork/massage.

◯ I understand that the client/practitioner relationship will be held in strict confidence.

◯ I will let my therapist know if the pressure is not to my liking ( if I would like more or less pressure ) or if something is uncomfortable.

◯ I understand that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) will be charged in full for the price of the missed session.

signature_____ date_____

Official use only

Address Book ◯ _____ _____ Direct Mail ◯ _____ _____