Roswell Massage and Reflexology
Davida Cohen
678.687.5669

Confidential Client History

Date:_____

Personal Information:

Name_____ Occupation_____

Address_____ City, State, Zip_____

Phone (H)_____ (C)_____ (W)_____ # of children_____

Email_____ Date of Birth_____ Age_____

How did you hear about Roswell Massage and Reflexology? _____

Emergency Contact/Relationship_____ Phone_____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Yes No

❒ ❒ Have you had a professional massage before?

❒ ❒ Do you have any difficulty lying on your front, back or side?

❒ ❒ Do you have any allergies to oils, lotions, or ointments?

❒ ❒ Do you sit for long hours at a workstation, computer, or driving?

❒ ❒ Do you perform any repetitive movement in your work, sports, or hobby?

❒ ❒ Do you see a chiropractor or physical therapist?

❒ ❒ Are you wearing contact lenses? Dentures?

1. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?

   _____

2. Do you have any particular goals in mind for this massage session?_____

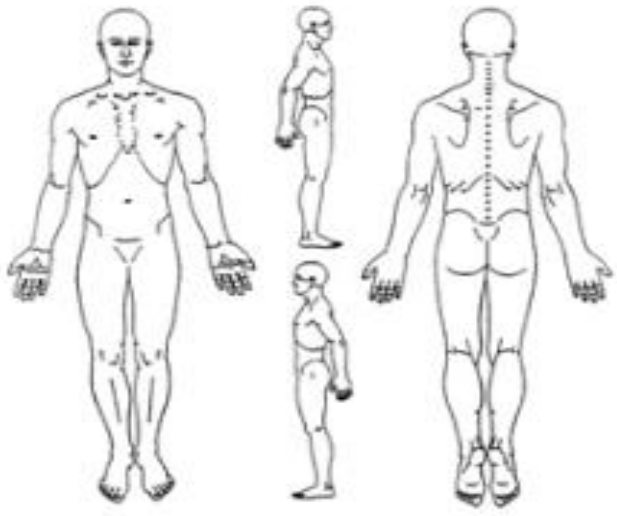
3. Are you currently under medical supervision? If so, please explain _____

   _____

4. Do you experience stress in your work [ ], family [ ], or other aspect [ ] of your life? If yes, how to you think it has affected your health? Muscle tension [ ] anxiety [ ] insomnia [ ] irritability [ ]
   Other_____

5. **Please list any medications you re currently taking** _____

_____



Circle any specific areas you would like the massage therapist to concentrate on during the session

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Medical History

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

PLEASE CHECK IF YOU HAVE A HISTORY OF THE FOLLOWING (use the letter "P" next to anything that is no longer relevant but happened in the past):

☐ Abdominal pain	☐ Contagious skin disorders	☐ Lupus	☐ Skin condition
☐ Accidents (car, fall, etc.)	☐ Decreased range of motion	☐ Mastectomy	☐ Spinal fusions
☐ Addictions	☐ Depression	☐ Menopause	☐ Sprains/strains
☐ Allergies/sensitivities	☐ Diabetes	☐ Mid back pain	☐ Stroke
☐ Anemia	☐ Dizziness	☐ Multiple Sclerosis	☐ Swollen glands
☐ Anxiety	☐ Epilepsy	☐ Muscle spasms	☐ TB
☐ Arthritis: type_____	☐ Fatigue	☐ Neck pain	☐ Tennis elbow
☐ Blood clots/Phlebitis	☐ Fibromyalgia	☐ Nervous tension	☐ Thyroid problems
☐ Blood pressure – High/Low	☐ Gout	☐ Neuropathies	☐ Tingling in arms/hands
☐ Breast augmentation	☐ Headaches/migraines	☐ Osteoporosis	☐ Tingling in legs/feet
☐ Broken bones	☐ Heart condition	☐ Parkinsons	☐ TMJ
☐ Bruise easily	☐ High stress	☐ Plantar fasciitis	☐ Tumors/cysts
☐ Bulging/ruptured disc	☐ HIV/AIDS	☐ PMS	☐ Ulcers
☐ Bursitis: where_____	☐ Indigestion	☐ Pregnancy	☐ Upper back pain
☐ Cancer: type_____	☐ Insomnia	☐ Sciatica	☐ Varicose veins
☐ Carpal tunnel syndrome	☐ Internal pins/plates/screws	☐ Scoliosis	☐ Wear contacts
☐ Cold hands/feet	☐ Joint aches	☐ Seizures	☐ Whiplash
☐ Colitis/Celiac disease	☐ Loss of balance	☐ Shoulder pain	☐ Other_____
☐ Constipation	☐ Low back pain	☐ Sinus trouble	☐ _____

_____

_____

_____

PARENT OR LEGAL GUARDIAN PLEASE NOTE:

- Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session and informed written consent must be provided by parent or legal guardian.
- ***Consent to Treatment of Minor:*** By my signature below, I hereby authorize_____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____

I,_____(**print name**) understand that the massage and/or bodywork I receive is provided for the basic purpose of relaxation, relief of muscular tension and creating balance in the body. 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 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.

Signature of client_____

Signature of Massage Therapist_____

CANCELLATION & LATE POLICY

24-hour advance notice is requested for all cancellations and changes to appointments. To protect the valuable time of all clients and the therapist, if a client does not show to a scheduled appointment, or give the requested 24-hour courtesy notice, they will be charged for that session. Clients arriving late will receive massage therapy for the remaining time of their scheduled appointment so that the next client's appointment is not disrupted. Please feel free to ask any questions or express any concerns regarding this policy.