Focused Care Therapeutic Massage

Name:____

Address:____

Phone:_________________ City____________________ State_______ Zip___________

Date of Birth__________ Glasses Contacts

Occupation:____

Are you allergic to nuts or nut oils? Y/N Do you have any sensitivities to essential oils? Y/N

List any medications you are taking____

List areas of pain and/ or tension:____

When did the discomfort start?____

Is there a physician treating you now or recently?_______ Physician's

Name:__________________

If yes, for what condition(s)?____

If you have, or within the last few years, have had, any of the following, please indicate:

Abdominal pain	Decreased range of motion	HIV	Nervous Tension	Stroke
Accident/ whiplash	Diabetes	Upper back pain	Osteoporosis	Surgery
Arthritis	Disk Problems	Low back pain	Seizures	Painful Joints
Broken Bones	Heart Attack	Mid back pain	Sprains	Varicose Veins
Cancer	High Blood Pressure	Neck Pain	Stiffness	Trouble Sleeping

Emergency contact name_____________________ phone #_________________

relationship__________

I have completed this form to the best of my knowledge and will inform the massage therapist of any change in my physical health. I understand that the massage therapist cannot diagnose illness, disease, or any other medical, physical, or emotional disorder, not perform any spinal manipulations. I understand that if the massage therapist starts a session late, she will make it up to me at the end of my session if possible, or will reduce my fee accordingly.

I agree to give 24 hour notice for a scheduled session that I cannot keep or pay $35 late cancellation fee.

Client Signature____ Date________________________