

Calming Touch Client Information Form

Name: _____ Date _____

Address: _____

Contact phone # _____ Email: _____

DOB (optional) _____ Occupation: _____

How did you hear about us? _____

Emergency contact person/phone: _____

Approximate weight: _____ Height _____ Male or Female _____

Are you currently under the care of a health professional? If so, please list name and phone number:

List any medications taking: _____

Type of exercise and how often _____

Please list any injuries, broken bones or surgeries and occurrence date(s): _____

Please circle any of the following conditions you are experiencing:

Emotional changes
Hypoglycemia
Heart ailment
Infectious condition
Kidney ailment
Cancer
Chronic/acute pain
Fibromyalgia

Headaches
Phlebitis
Diabetes
Sleeplessness
Allergies
TMJ syndrome
Digestive problems
Osteoporosis

Skin disorders
PMS
Pregnancy
Flu/cold/fever
High blood pressure
Varicose veins
Arthritis
Carpal tunnel syndrome

Other: _____

I understand that if I experience any pain or discomfort during my session(s), I will immediately inform the certified massage therapist (CMT) in order for the pressure and/or strokes to be adjusted to my level of comfort. I further understand massage/bodywork should not be considered a substitute for medical examination, diagnosis or treatment. I should see a qualified medical professional for any mental or physical ailments that I experience. I understand the CMT is not qualified to perform spinal or skeletal adjustments, diagnose or treat any physical or mental illness, or prescribe any medications. Nothing said during the session(s) should be interpreted as such. Because massage or bodywork should not be done under certain medical conditions, I affirm that I have stated all of my known medical conditions and have answered all questions honestly. I agree to keep the CMT updated as to any changes in my medical profile and understand that there shall be no liability on the CMT's part should I forget to do so. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session.

Signature _____ Date _____

Parent's Signature _____

(This is required if the client is under 18 years of age.)

Date _____ CHANGE IN HEALTH PROFILE? Yes ___ No ___ Client's initials _____

Date _____ CHANGE IN HEALTH PROFILE? Yes ___ No ___ Client's initials _____

Date _____ CHANGE IN HEALTH PROFILE? Yes ___ No ___ Client's initials _____

Date _____ CHANGE IN HEALTH PROFILE? Yes ___ No ___ Client's initials _____
