Austin Professional Massage Therapy
Client Information

Name: Telephone: ( ) Date of Birth:

Address: City: State: Zip:

Emergency Contact: Telephone: ( )

Referred by:

General & Health Information

Occupation : Male Female

Are you basically in good health? Y N

Have you been told by a physician you should not receive a massage? Y N

Has there been any change to your health in the past year? Y N

If so, please explain:_____

Are you currently being treated by a physician? Y N

If so, explain:_____

Reason for treatment today?_____

Do you have or have you ever been treated for any of the following?

__Arthritis
__High/Low Blood Pressure
__Epilepsy/Seizures
__Claustrophobia
__Varicose Veins
__Heart Disease
__Diabetes
__Asthma
__Cancer
__Any Blood Disorders
__Seborrhea

Any contagious disease? Y N

Are you pregnant/nursing? Y N

Do you wear contacts? Y N

Comments on any conditions:_____

Do you wear dentures? Y N

Do you have a pacemaker? Y N

Do you exercise regularly? Y N

How much water do you drink a day? ____glasses

Overall stress level?

High Medium Low

What type of massage would you like to receive?

_____

Are there any areas that should be avoided during the massage? _____

Have you experienced a professional massage? Y N How recently?_____

I understand that the massage I receive is provided for the basic purpose of a relaxation and relief of muscle tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure will be adjusted. I further understand that any physical ailment of which I am aware, should only be diagnose or prescribe any treatment, physical or mental, and that nothing said during the course of the session should be construed as such. Because certain massage should not be performed under a certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated to any changes in my medical profile and that there shall be no liability on the therapists, Austin Professional Massage Therapy or The Beauty Store Salon and Spa part should I fail to do so. I understand that should the therapist and I agree to a non-draping massage that written consent will be obtained prior to the treatment. I understand that should either party become uncomfortable during the session due to unprofessional or illicit behavior, the session will be terminated.

Client Signature:_____Date:_____

Consent of treatment of minor: By my signature below, I hereby authorize_____to administer massage techniques to my child or dependant, as they deem necessary.

Signature of Parent or Guardian:_____Date:_____