

Massage by Melody

Client Health Form

Name _____ Telephone _____

Address _____ City _____ Zip _____

Occupation _____ Emergency Contact _____ Phone _____

Male _____ Female _____ Date of Birth _____ Physician _____

If You Answer yes to any of the following questions please explain.

General

_____ Allergies

_____ Dizziness or Fainting

_____ Headaches

_____ Tension

_____ Migraines

Muscles & Joints

_____ Bursitis

_____ Arthritis

_____ Tendonitis

_____ Low Back Pain

_____ Neck & Shoulder Pain

Ears, Eyes, Nose & Throat

_____ Contacts

_____ Earaches

_____ Sinus Infections

_____ Nasal Obstructions

Pain, Numbness & Cramps

_____ Shoulders

_____ Arms

_____ Elbows

_____ Hip

_____ Hands

_____ Feet

Cardiovascular

_____ High Blood Pressure

_____ Low Blood Pressure

_____ Poor Circulation

_____ Swelling of Ankles

_____ Rapid Heart Beat

_____ Arrhythmias

Respiratory

_____ Asthma

_____ Chest Pain

_____ Difficulty Breathing

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage & bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. I further understand that massage or bodywork should not substitute for a medical examination, diagnosis or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailments that I am aware of. I agree to keep the practitioner updated as to any changes my medical profile. I also understand that any illicit or sexually suggestive remarks or advance made by the client will result in immediate termination of the session & I will be liable for payment of the scheduled appointment.

Client Signature _____ Date _____