Client Information form for Swedish or Myofascial Release:

Name:_____Phone:_____DOB:_____
Address:_____City:_____State:_____Zip:_____
Email:_____
Referred by:_____
In case of emergency:_____Phone:_____

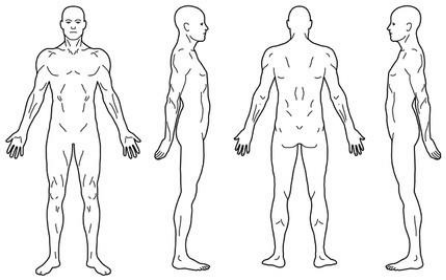
General & Medical Information:

Occupation:_____ Male__Female__
Are you basically in good health? Yes__No__
Has there been any change to your health in the past year? Yes__No__
If so, please explain_____
Physician:_____Phone:_____

Please take a moment to carefully read and answer the following questions. This section will be discussed before massage. Thank you.

Are you taking any medications (including non-prescription drugs)?_____
If so, which ones? _____
How would you describe your overall level of stress? Low__Medium__High__
Are you pregnant?_____Due Date:_____
Do you have heart problems?_____Pacemaker?_____
High Blood Pressure?_____If so what medication are you taking?_____
Diabetes?_____Lung or Kidney disease?_____Blood Disorders?_____
Do you have Asthma?_____If so, is it under control?_____
Arthritis, and if so where?_____
Do you have or have you ever had cancer?_____Date_____
Chemotherapy?_____Radiation?_____Date_____
Any skin allergies?_____
Are you allergic to any Essential Oil Scents (such as Eucalyptus…)?_____
Any circulatory problems?_____
Do you have varicose veins or distended capillaries?_____
Digestive problems?_____IBS?_____Reflux?_____
Sinus problems?_____Do you suffer from headaches/migraines?_____
Do you have TMJ?_____Bite Guard?_____
Have you ever had any surgeries?_____Explain_____
Are you currently being treated by a physician for any condition?_____
Do you have any other medical condition that I should be aware of?_____
_____
Have you ever had a massage before?_____Where?_____When?_____
What do you hope to accomplish today? _____

Using the pain scale below, how would you rate your discomfort?
Today: (no pain) **0 1 2 3 4 5 6 7 8 9 10** (worst pain imaginable)
Typical day: (no pain) **0 1 2 3 4 5 6 7 8 9 10** (worst pain imaginable)
Please indicate the location of your pain with an X



Client Signature_____Date:_____

Client Agreement Form:

Please initial each of the following statements:	**Initial**
I am aware that draping will be used during the massage session	_____
I understand that it is not within the scope of the massage session for the therapist to engage in breast massage of the client. They may massage the rib and/or the upper chest areas.	_____
I understand that *my* feedback is an essential element in my treatment. Therefore, if at anytime I should become uncomfortable during the massage, I will bring it to my therapist's attention and request that the session end.	_____
The therapist has reviewed with me the massage procedures, what muscles will be massaged and what will be avoided.	_____
I understand that the therapist may stop the massage at anytime if they feel that I have been inappropriate in my behavior or remarks.	_____
If I am unable to keep an appointment, I understand that a 24hr. notice is required, otherwise, I will be charged for the time reserved.	_____

Please read and sign the following agreement:

I have provided all health and medical information to the therapist so that a determination may be made as to the suitability of my receiving massage. I understand that massage techniques I receive are provided for the basic purpose of relaxation and relief of muscular tension. If I experience 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 also understand the therapist does not diagnose or prescribe for medical illness, disease, or any other physical or mental disorder. The therapist does not perform spinal manipulations. I understand that massage therapy is not a substitute for medical examinations and/or diagnosis and it is recommended that a physician be seen for any medical ailment you may have. Because massage should not be performed under 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 as to any changes in my medical profile and understand there shall be no liability on the therapist's parts should I fail to do so.

With this in mind, I agree to have the massage done and hereby release in full and forever discharge Carolyn H. Kuiken, the Staff, Employees, Officers, Guests, Agents and any and all parties from any and all liability, damages, claims, demands and/or causes of action relating to or deriving from any injury to me during or arising out of the use of the facilities or participation in any massage including all risk connected therewith, whether seen or unforeseen.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

Consent to treatment of a minor: By my signature below, I hereby authorize Carolyn H. Kuiken to administer massage modalities to my child or dependent, as they deem necessary.

Signature of Parent or Guardian_____ Date:_____

Name of Child_____