Alicia Bunting Massage Therapy

Name:_____ Phone(_____)_____DOB_____

Address_____ City_____ State _____Zip_____

Email_____

In case of emergency:_____Phone(____)_____

Occupation_____

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.

Have you ever experienced a professional massage or bodywork session? Yes ___ No___ When?_____	What kind of pressure do you Prefer? (Indicate below)		
	LIGHT	MEDIUM	DEEP

Do you bruise easily?	**YES**	**NO**	**Do you have diabetes?**	**YES**	**NO**
Are you wearing contact lenses?	**YES**	**NO**	**Do you experience frequent headaches?**	**YES**	**NO**
Do you have osteoporosis?	**YES**	**NO**	**Are you pregnant?**	**YES**	**NO**
Do you suffer from arthritis?	**YES**	**NO**	**Do you have varicose veins?**	**YES**	**NO**
Do you suffer from epilepsy or seizures?	**YES**	**NO**	**Do you have high blood pressure?**	**YES**	**NO**
Do you suffer from back pain?	**YES**	**NO**	**Are you taking high blood pressure medication?**	**YES**	**NO**
Do you have numbness or stabbing pains?	**YES**	**NO**			

If you answer "yes" to any of the following questions, please explain as clearly as possible.

Do you suffer from joint swelling?	YES	NO	**Any broken bones in the past two years?**	YES	NO
Have you ever had surgery? Explain below	YES	NO	**Are you sensitive to touch or pressure in any area?**	YES	NO
Any serious injuries in the past two years?	YES	NO	**Any other medical condition, or are you taking any medications I should know about?**	YES	NO
Do you frequently suffer from stress?	YES	NO	**Do you have cardiac or circulatory problems?**	YES	NO
Do you have any contagious diseases?	YES	NO	Other:		

I understand that the massage/bodywork I receive is provided the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to your level of comfort. I further understand that treatment should not be construed as for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment. I understand that massage/bodywork practitioners arc not qualified to perform spinal or skeletal adjustments. diagnose, prescribe or treat any physical or mental illness and that nothing said in the course of the session given should be construed as such. Because massage/ bodywork should not be performed under certain medical conditions, I affirm that I have stated all known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part if I fail to do so. I also understand any Illicit or sexually suggestive remarks or advances to therapist will result in immediate termination of the session. I will be liable for payment of the scheduled appointment.

Client Signature_____Date_____

Practitioner Signature_____Date_____

Consent to Treatment of Minor: I hereby authorize, Alicia Bunting to treat to my child or dependent.
Signature of Parent or Guardian_____Date_____