

Listening Touch Massage

Welcome! Thank you for taking the time to fill out this form. All information will be kept confidential.

Name _____	Date _____	Date of Birth _____
Address _____		<input type="checkbox"/> Home Phone _____
City _____ State _____ Zip _____		<input type="checkbox"/> Work Phone _____
Email _____		<input type="checkbox"/> Cell Phone _____ (Please check your preferred phone)

Occupation _____ Emergency Contact Name _____

Employer _____ Emergency Contact Phone _____

Are you currently under a doctor's care? Yes / No (if yes, please describe) _____

Primary Physician or Healthcare Provider: _____ Healthcare Provider's Phone _____

How did you find Listening Touch Massage? _____

Have you received professional massage or bodywork before today? Yes / No Favorite style/technique(s) _____

Do you exercise? Yes / No How often? _____ What type? _____

Are you currently taking any **prescribed medications** or **pain medications**? Yes / No (If yes, please list, along with condition) _____

Have you had any **major surgeries or injuries**? Yes / No If yes, please make note of them in the space provided with date(s): _____

What are your major complaints and symptoms today? _____

What are your needs and expectations for this treatment? _____

Do you have allergies to nuts, lotions, oils or creams? Yes or No If yes, please describe: _____

Do you have any of the following? **please circle**: Contacts Dentures Hearing aids Wig Pacemaker IV/Port Bone pin/s Spinal rods

Please check any of the following conditions that you have a history of or currently have:

Blood, Heart and Circulatory

- Bruise Easily Anemia
- Varicose veins Swelling/Edema
- Lymphedema Location: _____
- Lymph node removed or radiated
- Blood Clots Stroke
- Low Blood Pressure
- Heart Condition _____

Chronic Pain / tension

- Back lower middle upper
- Neck Shoulders Hip/s
- Knee/s _____

Bone, Joint & Muscle

- Broken/Dislocated _____
- Disc bulging herniated _____
- Arthritis Location(s): _____
- Tendonitis/Bursitis _____
- Carpal Tunnel Syndrome

Do you suffer from:

- Headaches Migraine Tension
- Sleeping Problems
- Anxiety Depression
- Digestive Problems _____

Women Only:

- Are you pregnant? yes / no Due Date: _____
- Previous Pregnancies _____
- PMS/PMDD Menopausal Symptoms
- Breast Pain / Cysts / Swelling
- other _____

Men Only: Prostate Problems

Viral/ Skin Problems

- Rash Fungus Warts
- Location: _____
- Shingles/Herpes
- other _____

Respiratory

- Seasonal Allergies Asthma
- Smoking History Sinus Problems
- other _____

Auto Immune, Nervous, Endocrine

- Diabetes Type I Type II
- Fibromyalgia Multiple Sclerosis
- HIV Lupus
- Neuropathy Rheumatoid Arthritis
- other _____

Cancer -Location(s) and date(s):

- _____
- Surgery _____
- Chemo _____
- Radiation _____
- Other _____

Is there any condition not listed above that your massage practitioner should be aware of? If yes, please list: _____

Informed Consent I, the undersigned agree to receive massage from Listening Touch, and I understand that massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, and improve circulation and provide a positive experience with touch. I am aware that my massage practitioner does not diagnose disease or illness, prescribe medications or perform skeletal manipulations. I comprehend that I **may terminate a massage session at any time** if I feel uncomfortable with the course of treatment. Therapist reserves the right to end session in the case of any inappropriate behavior. The benefits of massage therapy, possible contraindicating factors, and a treatment plan have been explained to me. I realize that the health benefits of massage therapy are not guaranteed, nor is massage therapy intended to be a substitute for supervised medical treatment by a doctor. I have informed my massage practitioner of all my known medical conditions and I agree to inform my practitioner of any changes in my health as they occur. I hereby assume full responsibility for receipt of the massage therapy, and release and discharge Therapist from any and all claims, liabilities, damages, or causes of action arising from the therapy received hereunder, including, without limitation, any damages arising from acts of active or passive negligence on the part of the Therapist, to the fullest extent allowed by law.

24-hour Cancellation Notice Policy I understand that this time has been reserved for me, and if I am unable to make a scheduled appointment, I agree to notify the therapist within 24 hours by telephone. I understand that this 24-hour notice is required to avoid being charged a **missed appointment charge of 50%** of the scheduled treatment fee.

I acknowledge receipt and comprehension of the Listening Touch policies for services and agree to the policies stated above.

Client's Signature: _____ Date: _____

