C___ CC___ TY___ B___

Alisa's SkinCare

MASSAGE THERAPY REGISTRATION AND HISTORY

CLIENT INFORMATION

Date _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

_____

City _____

State_____ Zip _____

E-mail _____

Sex ___ M ___ F Age ____ Birthdate_____

__ Married ___ Widowed ___ Single ___ Minor

__ Separated ___Divorced ___ Partnered for ___ years

Occupation _____

PHONE NUMBERS

Home (_____) _____

Cell (_____) _____

IN CASE OF EMERGENCY CONTACT

Name _____

Relationship _____

Home (_____) _____

Cell (_____) _____

REFFERALS & OFFERS

Who may we thank for referring you? _____

_____

Or how did you find us? _____

MASSAGE HISTORY

Have you ever received a professional massage? __Y __N

If yes, how often do you receive massage therapy? _____

_____

If yes, do you have a style or pressure preference? _____

_____

Specify: __ Light Pressure __Medium Pressure

__ Deep Pressure __Other

MASSAGE TODAY

What type of massage are you seeking today?

__ Relaxation __ Deep Tissue/Therapeutic __ PreNatal

__ Senior __ Integrated Bodywork __ Other

What results would you like to achieve? _____

_____

Prioritize the areas of your body that you wish to be massaged.

_____

_____

Please note any areas of your body that you **prefer not to be** massaged.

_____

_____

Are you sensitive to fragrances or perfumes? __Y __N

Would you like me to use essential oils (Aromatherapy) for your massage experience? If so, do you have any preferences?

_____

What does the rest of your day look like? Do we need to preserve your hair, or is a scalp massage acceptable?

_____

_____

Work Activity: ___Sitting ___Light Labor

___Standing ___Heavy Labor

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MEDICAL HISTORY

Do you have sensitive skin? ___Y ___N

Do you wear contact lenses? ___Y ___N

Do you exercise regularly? ___Y ___N

Do you have any allergies? ___Y ___N

If so, what type(s)? _____
___Daily ___Moderate ___Heavy

If so, explain:_____

What are your common areas of pain or tension? _____

Do you suffer from chronic or persistent pain or discomfort? _____

If so, for how long? _____ Do you know what caused it or when the symptoms seem to get worse or better?

_____

Do you see a Chiropractor? ___Y ___N If so, how often? _____

Are you currently being treated for any health condition or injury?	___Y	___N
Are you pregnant?	___Y	___N
Have you had surgery, including dental surgery, in the last two years?	___Y	___N
Have you had any serious injuries in the last two years?	___Y	___N
Do you have any medical implants such as IUD, a stent, artificial joint or pacemaker?	___Y	___N
Are you taking immune suppressing medications for any reason?	___Y	___N

Are you currently taking any medications, either prescribed by a physician or over-the-counter?

Medication	Taking For
_____	_____
_____	_____
_____	_____

Vitamins/Herbs/Minerals _____

Do you have any of the following conditions? We will briefly discuss conditions that you have marked below.

Allergies or Sensitivities	___Y	___N	Joint Pain	___Y	___N
Anemia	___Y	___N	Joint Replacement/Surgery	___Y	___N
Anorexia	___Y	___N	Kidney or Liver Disease	___Y	___N
Arthritis/Tendonitis	___Y	___N	Lack of or Reduced		
Asthma	___Y	___N	Feeling/Sensation	___Y	___N
Back Pain	___Y	___N	Low Blood Pressure	___Y	___N
Blood Clot or Phlebitis	___Y	___N	Major Accident	___Y	___N
Blood Pressure	___Y	___N	Neck/Back Injuries	___Y	___N
Bruises	___Y	___N	Numbness or sharp pain	___Y	___N
Cancer/Tumors	___Y	___N	Osteoporosis	___Y	___N
Cardiac Disease	___Y	___N	Pacemaker	___Y	___N
Chemical Dependency	___Y	___N	Paralysis	___Y	___N
Diabetes	___Y	___N	Recent Injuries	___Y	___N
Emphysema	___Y	___N	Sinus Problems	___Y	___N
Epilepsy	___Y	___N	Skin condition	___Y	___N
Fibromyalgia	___Y	___N	Sprain/Strain	___Y	___N
Headaches/Migraines	___Y	___N	TMJ/Jaw Problems	___Y	___N
Heart/Circulation Issues	___Y	___N	Ulcers	___Y	___N
Hernia	___Y	___N	Varicose Veins	___Y	___N
			Whiplash	___Y	___N

Scars? Where:_____

Lifestyle

___ Smoking Packs/Day ____
___ Alcohol Drinks/Week ____

Coffee/Caffeine Cups/Day ____
High Stress Level Reason _____

Physician

Physician's Telephone

Alisa's SkinCare

AUTHORIZATION

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form and I understand that it is my responsibility to inform my health care provider if I ever have a change in health.

I understand that massage therapy services are for the primary purpose of short-term relaxation and the relief of muscular tension. I understand that massage therapy services are in no way a substitute for examination, diagnosis or treatment by a physician. I understand that individuals providing massage therapy services are not qualified to diagnose, prescribe or treat any physical or mental illness and are not qualified to perform spinal or skeletal adjustments. I acknowledge that any information I receive from individuals performing massage therapy services is educational in nature and is to be used at my own discretion.

Policies and Disclosures - The purpose of this massage is to provide stress relief, pain control and relaxation. I do not expect, nor will I ask, my therapist to diagnose, prescribe for, or treat any of my symptoms. I understand that I am responsible for my emotions, feelings, body and belongings and that the therapist if responsible for giving a massage. Control of the session is mine and I agree to tell the therapist if I am uncomfortable in any way. I have the right to end the session if I am not satisfied. I understand that in order to receive a massage, it is necessary to remove my clothes. Anyone receiving a massage will be modestly covered with a sheet at all times.

Medical Conditions - Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and have answered all questions honestly. In the spirit of this understanding, I agree to hold Alisa's Skin Care blameless from any problem, which might arise as a result of my massage sessions.

Intoxicants - It is the policy of this facility that for safety and health of employees and clients, massage services will be denied to clients who appear to have consumed alcohol or drugs prior to their appointment or who appear to be under the influence of alcohol or drug consumption when they arrive for their appointment. I agree to comply with this policy.

Infectious Conditions - Anyone who has a contagious infection such as a cold or the flu, or who has a contagious skin condition such as impetigo, should not give or receive a massage until the condition is no longer contagious.

Sexual Harassment - Sexual harassment is illegal and Alisa's Skin Care has a zero tolerance for sexual harassment. I will not ask any employee of this facility to discuss or perform a sexual act. I understand that the therapist is not allowed to engage in a discussion of a sexual nature and that the massage will be terminated if I attempt to do so.

Cancellation Policy - Our time together is important. It is requested that you cancel your appointment 24 hours in advance or pay the missed appointment fee in full. Call and leave a message on voice mail to cancel appointments or change scheduling. You may cancel your appointment online directly if that is how you booked your original appointment. Clients who fail to show up for their scheduled appointment time will not be scheduled for future appointments. Gift certificates may be forfeited for cancellations with less than 24 hours notice. Gift certificates will be forfeited for no shows.

Lateness Policy - We request that you arrive early for your appointment. Our massage therapy policies state: If you arrive late for your appointment, the time left will be used to its best advantage.

Sickness Policy - Recognizing that both massage therapists and clients are vulnerable to infections, we therefore ask clients to cancel appointments when they are feeling unwell. If you have any of the following contagious illnesses the massage session will be rescheduled: Diarrhea, Vomiting, Fever, Chicken Pox, Measles, Mumps, Meningitis, Hepatitis A, Conjunctivitis, Rubella, Head Lice, Impetigo, Influenza, Meningococcal Disease, Polio, Ringworm of the body, feet or scalp, Scabies, Thrush, Whooping Cough and the Common Cold.

By signing below, I acknowledge that I have read the policies and disclosures on this form and agree to abide by them.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Date