

Shawna Johnston, LMT

Address: Contact phone #: Email: Contact phone #: Email: How did you hear about us? [] Healing Arts Center Referral, Name:	Client Information		
Email: Emergency Contact: Emergency Contact: Emergency Contact: Contact's phone #: How did you hear about us? [] Healing Arts Center Referral, Name:	Name:	Today's Date:	
Contact phone #:		Birthdate:	
Email: Contact's phone #: How did you hear about us? [] Healing Arts Center Referral, Name: [] Drive by [] Internet [] Brochure [] Friend/Family, Name: Have you ever had a professional massage? Yes Do you currently have any diagnosed conditions? Please describe any significant body injuries and surgeries you can remember: Are you currently on any medications? Do you have any allergies? Please indicate areas of pain or discomfort Please check the appropriate boxes [] Heart condition [] Migraines/Headaches [] Stroke [] Jaw Pain (TMJ) [] Blood Clots [] Spinal problems [] Fibromyalgia [] High/Low Blood Pressu [] Caneer/Tumors [] Sinus problems [] Diabetes [] Sinus problems [] Asthma/Breathing issue [] Contagious disease [] Osteoporosis [] Contagious disease [] Osteoporosis [] Contagious disease [] Arthritis [] Digestive issues [] Arthritis [] Digestive issues [] Arthritis [] Digestive issues [] Arthritis [] Digestive issues [] Arthritis [] Digestive issues [] Arthritis [] Digestive issues [] Arthritis [] Digestive issues [] Arthritis [] Digestive issues [] Arthritis [] Digestive issues [] Osteoporosis [] Contagious disease [] Contagious disease [] Arthritis [] Digestive issues [] Arthritis [] Digestive issues [] Osteoporosis [] Contagious disease [] Other: Please list your goal(s) for this massage session: Please list any details or additional information: I understand that massage therapy is not a substitute for medical treatment or medications and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications and that spinal manipulations are not part of massage therapy. I have informed the massage therapist of all my known physical conditions. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any perfinent information. If levorent in the therapists to the teament and the adjusted. Sexual c	Contact phone #:	Emergency Contact:	
Have you ever had a professional massage? Yes			
Please describe any significant body injuries and surgeries you can remember: Are you currently on any medications? Do you have any allergies? Please indicate areas of pain or discomfort Please check the appropriate boxes [] Heart condition [] Migraines/Headaches [] Stroke [] Jaw Pain (TMJ) [] Blood Clots [] Spinal problems [] Fibromyalgia [] High/Low Blood Pressu [] Cancer/Tumors [] Tendonitis/Bursitis [] Diabetes [] Sinus problems [] Bone or Joint Disease [] Epilepsy/Seizures [] Osteoporosis [] Contagious disease [] Arthritis [] Digestive issues [] Pregnant: Stage [] Other: Please list any details or additional information: Please list any details or additional information: I understand that massage therapy is not a substitute for medical treatment or medications and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications and that spinal manipulations are not part of massage therapy. I have informed the massage therapist of all my known physical conditions, medical conditions, and medications and it it is recommended that I concurrently work with my Primary Caregiver for any condition are not part of massage therapy. I have informed the massage therapist of all my known physical conditions, and medications and it it is respected with the presention of the	How did you hear about us? [] Healing Arts Center Referral, Name:		
Are you currently on any medications? Do you have any allergies? Please indicate areas of pain or discomfort Please check the appropriate boxes Heart condition	Have you ever had a professional massage? Do you currently have any diagnosed condition	Yes No ons?	
Please indicate areas of pain or discomfort Please check the appropriate boxes [] Heart condition [] Migraines/Headaches [] Stroke [] Jaw Pain (TMJ) [] Blood Clots [] Spinal problems [] Fibromyalgia [] High/Low Blood Pressur [] Cancer/Tumors [] Tendonitis/Bursitis [] Diabetes [] Sinus problems [] Bone or Joint Disease [] Epilepsy/Seizures [] Osteoporosis [] Contagious disease [] Arthritis [] Digestive issues [] Pregnant: Stage [] Other:	Please describe any significant body injuries	and surgeries you can remember:	
Heart condition Jaw Pain (TMJ)			
Heart condition Migraines/Headaches Jaw Pain (TMJ)	Please indicate areas of pain or discomfort	Please check the appropriate boxes	
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exhibited by the client will not be tolerated and will result in immediate termination of the session with the client liable for complete payment of the scheduled appointment. All the information provided above is, to the best of my knowledge, correct and current. Signature: Date:	my Primary Caregiver for any condition I may have. I am aware to medications and that spinal manipulations are not part of massac conditions, medical conditions, and medications and it is my responditions. I understand that there shall be no liability on the prayany pain or discomfort during the session, I will immediately comexhibited by the client will not be tolerated and will result in immediately defined appointment. All the information provided above is, to	ge therapy. I have informed the massage therapist of all my known physical ponsibility to keep the massage therapist updated on any changes on new actitioner's part due to my forgetting to relay any pertinent information. If I experience inmunicate that to the therapist so the treatment can be adjusted. Sexual conduct rediate termination of the session with the client liable for complete payment of the other best of my knowledge, correct and current.	