Healing Arts Center

Shawna Johnston, LMT

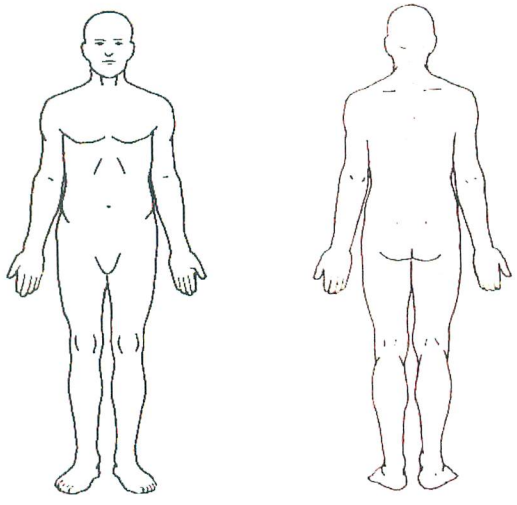
Client Information

Name: _____ Today's Date: _____
Address: _____ Occupation: _____
_____ Birthdate: _____
Contact phone #: _____ Emergency Contact: _____
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 No
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
[ ] Stroke
[ ] Blood Clots
[ ] Fibromyalgia
[ ] Cancer/Tumors
[ ] Diabetes
[ ] Thrombosis Embolism
[ ] Bone or Joint Disease
[ ] Osteoporosis
[ ] Arthritis
[ ] Pregnant: Stage _____
[ ] Migraines/Headaches
[ ] Jaw Pain (TMJ)
[ ] Spinal problems
[ ] High/Low Blood Pressure
[ ] Tendonitis/Bursitis
[ ] Sinus problems
[ ] Asthma/Breathing issues
[ ] Epilepsy/Seizures
[ ] Contagious disease
[ ] Digestive issues
[ ] Other: _____

Please list any details or additional information:
_____
_____

Please list your goal(s) for this massage session: _____
_____

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 is my responsibility to keep the massage therapist updated on any changes on new conditions. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information. If I experience any pain or discomfort during the session, I will immediately communicate that to the therapist so the treatment can be adjusted. Sexual conduct 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: _____