



**CLIENT INFORMATION**

Name \_\_\_\_\_ Email Address \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_ DOB \_\_\_\_\_

Emergency Contact Person: Name \_\_\_\_\_ Phone \_\_\_\_\_

Occupation \_\_\_\_\_ How did you hear about us? If referred, list their full name \_\_\_\_\_

1) Have you ever had massage therapy before? \_\_\_\_\_ What kind? \_\_\_\_\_ How often? \_\_\_\_\_

2) What do you want to accomplish with today's massage? List any areas that you want focused on \_\_\_\_\_

3) Are there any areas you do not want to be massaged? (ex: face, scalp, feet) \_\_\_\_\_

4) Is there anything in particular that you have not liked with previous massage? \_\_\_\_\_

5) What kind of pressure do you prefer? (X) Light \_\_\_\_\_ Medium \_\_\_\_\_ Firm \_\_\_\_\_ Mixed \_\_\_\_\_ Deep Tissue \_\_\_\_\_

6) Do you have any allergies or sensitivities to oils, lotions, scents, etc? \_\_\_\_\_

7) Are you presently being seen by a doctor? \_\_\_\_\_ If so, for what conditions? \_\_\_\_\_

8) List any medications/supplements you are now taking \_\_\_\_\_

- 9) Please mark (X) if any of the following apply to you: Any that are marked, please explain in the comment section
- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Neck Pain           | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Varicose Veins   | <input type="checkbox"/> HIV                           |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Fibromyalgia     | <input type="checkbox"/> Contagious Disease(s)         |
| <input type="checkbox"/> Shoulder Pain       | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Skin Disorders/Infections     |
| <input type="checkbox"/> Mid Back Pain       | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Carpal Tunnel    | <input type="checkbox"/> Thyroid Problems              |
| <input type="checkbox"/> Low Back Pain       | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Sinus Trouble    | <input type="checkbox"/> Anemia                        |
| <input type="checkbox"/> Disc Problems       | <input type="checkbox"/> Blood Clots          | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Allergies                     |
| <input type="checkbox"/> Hip Pain            | <input type="checkbox"/> Swelling             | <input type="checkbox"/> Constipation     | <input type="checkbox"/> TMJ                           |
| <input type="checkbox"/> Sciatica            | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Indigestion      | <input type="checkbox"/> Prostate Problems             |
| <input type="checkbox"/> Numbness            | <input type="checkbox"/> Low Blood Pressure   | <input type="checkbox"/> IBS              | <input type="checkbox"/> Restless Legs                 |
| <input type="checkbox"/> Tingling            | <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Menopausal       | <input type="checkbox"/> Dizziness                     |
| <input type="checkbox"/> Broken Bones        | <input type="checkbox"/> Use Tobacco Products | <input type="checkbox"/> Fatigue          | <input type="checkbox"/> Fainting                      |
| <input type="checkbox"/> Recent Injury       | <input type="checkbox"/> Use Alcohol Products | <input type="checkbox"/> Depression       | <input type="checkbox"/> Ringing in Ears               |
| <input type="checkbox"/> Recent Surgery      | <input type="checkbox"/> Irritability         | <input type="checkbox"/> Loss of Memory   | <input type="checkbox"/> Sleeping Problems             |
| <input type="checkbox"/> Mental Illness      | <input type="checkbox"/> Nervousness          | <input type="checkbox"/> Wear Contacts    | <input type="checkbox"/> Sensitivity to touch/pressure |

Comments: \_\_\_\_\_

10) Are you or could you be pregnant? \_\_\_\_\_ If so, how many weeks? \_\_\_\_\_ Complications/High Risk? \_\_\_\_\_

11) Are you interested in learning about our exclusive programs to help save you money on massage? \_\_\_\_\_

**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.) I understand that massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should consult a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/bodywork therapists are 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 my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability in the therapists part should I neglect to do so. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. If I am under 18 years of age, a parent or legal guardian must sign for approval of my getting massaged.

Signature of Client (or parent if client under 18) \_\_\_\_\_ Date \_\_\_\_\_



**Cancellation Policy for Massage Appointments**  
**(Revised 10/15/10)**

When a massage appointment is made, a certain amount of time is reserved just for you. We do what we can to be here when you need us, and we kindly ask that you be here when expected. Due to numerous missed appointments, we have established the following:

Eagle Creek Massage has instituted a policy in order to reduce the number of no-show or missed appointments for massage. We require a 4 hour notice for cancellation or reschedule of any appointment that you will not be able to attend. If this policy is not followed or if the appointment is no-showed, then you will be charged for the full amount of the visit.

Although we do our best to call the business day prior to your appointment, this is only a courtesy call and not to be considered a confirmation. Your appointment is considered confirmed the moment you schedule it.

Thank you for your understanding and anticipated cooperation.

*I have been made aware that a 4hour notice must be given in order to cancel any massage appointment. I agree to the above cancellation policy of massage services. I agree to keep a credit card on file with Eagle Creek Massage and will be charged if this cancellation policy is not followed for future appointments.*

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Printed name

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Signature

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Date