

Integrative Touch LLC
Massage Therapy
Client Information Form

Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Business Phone _____

How did you hear about this service? _____

Have you ever received massage therapy before? ___ Yes ___ No

Reason for today's visit (relaxation, pain, therapy, etc.): _____

Current medications: _____
(include over-the-counter pain relievers and herbal remedies)

Check any of the following that apply to your current health:

___infection ___heart condition ___circulatory conditions ___blood clots
___diabetes ___cancer ___difficulty breathing ___arthritis

Comments: _____

Are you currently seeing a healthcare professional for any other reason? _____

Have you had any traumatic accidents or operations? _____

Is there anything I should know to insure your comfort regarding:

- Allergies/sensitivities (oils, lotions etc.) _____
- Contact lenses (the face pillow may put pressure on your eyes): _____
- Hearing abilities (communication is helpful during the session): _____
- Movement abilities (i.e., getting on and of the table, etc.): _____
- Other / Comments: _____

Emergency Contact _____ Relationship _____

Home Phone _____ Business Phone _____

Consent for Care

It is my choice to receive massage therapy. I am aware of the health benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy, as well as information exchanged during any massage session is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. *I also agree to pay for missed appointments in full if less than 24 hours notice is given.*

Signature _____ Date _____