



Deep Comfort Massage Therapy

Client Information

Name _____ Telephone _____

Email _____ Date of Birth _____

Address _____

Referred By _____ Profession _____

Age _____ Height _____ Weight (approx) _____ Male/Female

Do you have a high degree of stress in your life? Yes No

Do you experience headaches frequently? Yes No

Are you pregnant? Weeks? _____ Yes No

Any allergies? If yes, to what? _____ Yes No

Do you have a pacemaker? Yes No

Arthritis? Where? _____ Yes No

Diabetes? Type? _____ Yes No

Hypertension? Yes No

Epilepsy or seizures? Yes No

Osteoporosis? Yes No

Varicose veins? Yes No

Cardiac or circulatory problems? Yes No

Any contagious diseases? Yes No

Bruise easily? Yes No

Any broken bones in the past 2 years? Yes No

Do you hold tension or have soreness in a specific area?

What kind of pressure do you like on a scale of 1 to 10 (10 being the hardest)? _____

Do you have any other medical conditions I should be aware of? _____

List all medications you are currently taking _____

Have you had Surgery before? Please explain _____

Do you: Exercise _____ How often? _____

Smoke or chew tobacco _____ How often? _____

Use alcohol _____ How often? _____

Use Caffeine _____ How often? _____

Client Statement

I am aware that all of the information I have provided on this page and anything that occurs during a session will be held in the strictest of confidence and will not be discussed with anyone unless I have given my written consent to do so.

I understand that the massage/bodywork I am to receive is for the basic purpose of relaxation and relief from muscular tension. If I begin to experience any pain or discomfort of any kind during a session, I agree to let my practitioner know immediately so the pressure and strokes will be altered to suit my particular comfort range.

I am also aware that massage/bodywork must not be construed as a substitute for any needed medical attention either from a physician, chiropractor or other qualified medical specialist, and I understand that it is beyond the scope of practice for my massage/bodywork practitioner to diagnose, prescribe or treat any mental or physical ailments and that nothing said in the course of a session should be construed as such.

Knowing that there are certain medical conditions where massage/bodywork would be contraindicated, I have filled out the above questionnaire to the best of my knowledge and answered all questions honestly.

I agree to keep the practitioner updated as to any changes of any medical condition and understand that there should be no liability on the practitioner's part if I fail to do so.

I also understand that any illicit or sexually suggestive remarks or advances made by me toward the practitioner will result in immediate termination of services and I will be liable for payment of the scheduled session.

Client Signature _____ Date _____

Consent to Treatment of a Minor

By my signature below, I hereby authorize *Paul Simmons* to administer massage, bodywork to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____