

Heartfelt Hands
Debi A. Gaul, LCMT

CLIENT INFORMATION & RELEASE FORM

NAME _____ DATE _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE _____ WORK PHONE _____ CELL _____
E-MAIL _____
DATE OF BIRTH _____ OCCUPATION _____
REFERRED BY _____
EMERGENCY CONTACT _____ TELEPHONE _____

Medical Information

Yes	No	
___	___	Are you wearing contact lenses?
___	___	Are you pregnant and if so how far? _____
___	___	Do you frequently suffer from stress?
___	___	Do you have any numbness or stabbing pains and if so, where? _____
___	___	Have you had any broken bones in the past two years, if so where? _____
___	___	Do you experience frequent headaches?
___	___	Are you sensitive to fragrances?

Have you ever had any surgeries, including cosmetic? If so, what type and list approximate dates.

Are you currently taking any medications and for what condition? _____

Please describe any current medical problems. _____

Check specific areas where you currently experience pain or discomfort:

___	Head	___	Arms	___	Knees	___	Neck
___	Hands	___	Lower Legs	___	Shoulders	___	Abdomen
___	Ankles	___	Chest	___	Pelvis	___	Feet
___	Lower Back	___	Middle Back	___	Upper Back	___	Hips

Have you had any of the following conditions? Please circle:

High Blood Pressure
Whiplash
Neck/Spine Injury
Sports Injury
Skin Disorders

Heart/Circulatory
Cancer
Diabetes
M.S.
Infectious Conditions

Respiratory Disorders
Osteoporosis
Arthritis
T.M.J.D.
Epilepsy

Any other conditions I should be aware of? _____

How is your sleep? _____ Do you exercise regularly? _____

Have you had a professional massage/bodywork session? _____

What did you like best about your session? _____

Is there anything you dislike in massage techniques? _____

Do you have any allergies to lotions or oils? _____

Do you have specific areas you would like to work on? _____

Are there any areas that are particularly sensitive, painful or that you don't want me to touch? _____

Is it OK for me to massage your head and face? _____

What would you like to get out of today's session? _____

Please take a moment and carefully read the following information and sign where indicated.

The above information is accurate to the best of my knowledge. I understand that the massage therapist, while trained in Massage Therapy, is not trained to diagnose or treat any form of illness, disease, or injury and that I will be receiving massage therapy as a form of adjunctive health care only, and that this therapy is not intended to replace appropriate medical care. I do forever release the therapists and their insurers from all liability of any nature whatsoever, whether past, present, or future for injury or damage which may occur as a result of my receiving massage therapy. I agree to hold harmless and defend the therapist of all actions, claims, or other legal or administrative action that has arisen or may arise from my participation in this therapy. 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. I also understand that anything discussed during my session will remain confidential.

As a service oriented business, my clientele is important to me. As a professional I structure my time to meet the greatest need. In doing such I have set the following cancellation policy. If for any reason you cannot keep an appointment please call at least 24 hours in advance to reschedule. This will aid in filling your appointed time. If this policy is not upheld you will be charged for your missed appointment. Less than 24 hour notice will be billed at half of your normal hourly fee. For no shows (no prior notice) you will be billed at full fee.

Signed _____ Date _____