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	Heart/Circulatory	Respiratory Disorders
Whiplash	Cancer	Osteoporosis
Neck/Spine Injury	Diabetes	Arthritis
Sports Injury	M.S.	T.M.J.D.
Skin Disorders	Infectious Conditions	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 MassageTtherapy, 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_____

COVID Addendum

Heartfelt Hands Massage

To best protect your health and the health of others, please fill out this form before massage and bodywork session. Thank you!

NAME: _____Date:_____

Have you been tested for COVID-19? If yes, what type of test did you have?_____

When was your test? What were the results? _____

Have you been in places with a high infection rate within the last two weeks (e.g., state designated "hotspots")? If yes, please explain._____

Please check if you are experiencing any of the following as a NEW PATTERN since the beginning of the pandemic:

__ Fever __ Chills __ Cough __ Sore throat __ Diarrhea, digestive upset __ Nasal, sinus congestion __

Loss of sense of taste or smell __ Fatigue __ Shortness of breath __

Sudden onset of muscle soreness (not related to a specific activity) _____

Rash or skin lesions (especially on the feet)_____

Do you have any new discomfort with exertion or exercise?_____

"I understand that close contact with people increases the risk of infection from COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage from this practitioner."

I declare that the information provided above is true and accurate to the best of my knowledge.

_____ (print name) _____ (signature)

_____ (date)