Client Health History

Name _____ **DOB**_____ **Phone ( ) _____**

Address _____ **City** _____ **State** ___ **Zip**_____

E-mail:_____**May we send emails/promotions @ email address? Yes No**

Occupation _____**How did you hear about us?** _____

Emergency contact:_____ **Phone ( )**_____

Under care of physician? Physician Name_____

Have you had a professional massage or bodywork session before? Yes No
If so, when?_____

What goals have you set for our sessions?_____

Have you had any alcohol in the past 24 hours? Yes No

What kind of pressure do you prefer? Light Medium Firm

Surgeries? Hospitalizations? Please list what/when _____

We have permission to massage which areas of the body: (CIRCLE ALL that apply)

Face Head Neck Ears Back Gluts Legs Arms Hands Feet

***CIRCLE* if you have any of the following:**

Stress
Tension/soreness
Joint swelling
Cardiac/circulatory problems
(medication?)_____
Frequent headaches
Numbness/stabbing pains
(where?) _____
Contagious diseases
(which?) _____
Allergies _____

Injuries/illness
Diabetes (medication?)_____
Arthritis (where?) _____
Varicose veins
Wearing contacts/dentures
Bruise easily
Low/high blood pressure (circle one)
(medication?)_____
Epilepsy/seizures (medication?)_____
Osteoporosis
Broken bones last 2 yrs? _____

Please list other medical conditions/medications/supplements I should know about

_____

_____

Prepared by Tammy Schleicher/Dreamscapes, LLC

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, a session of massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

I understand that the massage/bodywork/reflexology I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand 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 cancellation from client becomes necessary, **Dreamscapes, LLC** does require 24 hours notice of cancellation, and at our discretion a charge may be applicable if 24 hours notice is not given.

Client Signature _____ Date _____
Therapist Signature _____ Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize ***Dreamscapes,LLC*** to administer massage, bodywork, reflexology, or somatic therapy techniques to my child/dependent as they deem necessary.

Signature of Parent/Guardian _____ Date _____
Relationship to Minor_____

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