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Name_____DOB _____

Address_____City _____

State_____Zip_____ Phone ( )_____ Phone ( ) _____

E-mail: _____ Email & Text newsletters/specials? ☐ Yes ☐ No

Occupation_____ Male____Female____Other_____

Referred by:_____Phone ( ) _____

In case of emergency:_____Phone ( ) _____

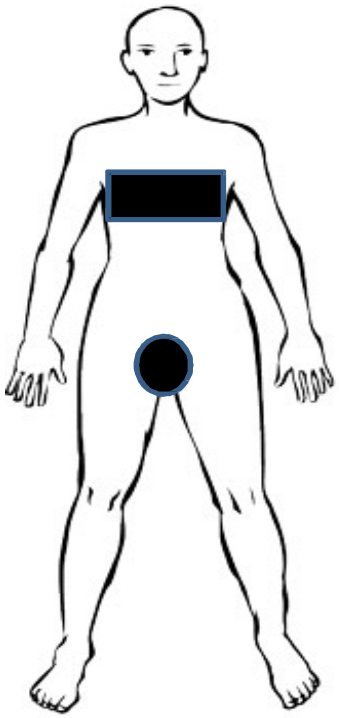
Physician_____Phone ( )_____

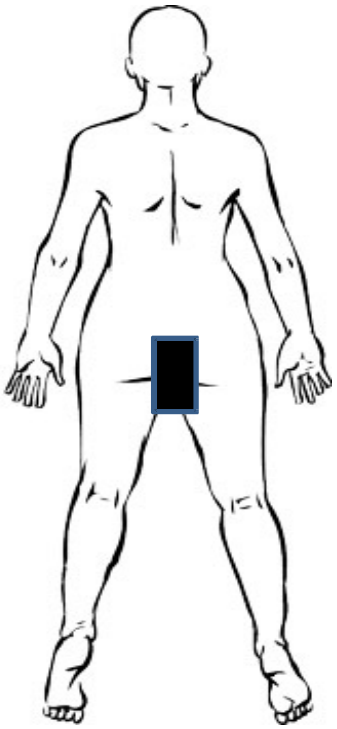
Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? ___Yes ___No How recently?_____

What are your massage or bodywork goals? _____

What kind of pressure do you prefer? light ☐ medium ☐ firm ☐ other_____





Use the body map to complete the following:

CIRCLE (O) any areas of your body that you want focused attention on.

CROSS OUT (X) any areas you would rather be avoided / not massaged during the session.

DOTTED LINE (- - -) any surgical or other deep / significant scar tissue.

Shaded areas will not be massaged.

If you answer "yes" to any of the following questions, please explain as clearly as possible.

Please list any sources of personal stress (mental, emotional, or physical):_____

_____

☐ Yes ☐ No Do you suffer from depression/anxiety, or any other mental illness? If yes, please list: _____

☐ Yes ☐ No Do you have diabetes? If yes, controlled by what means? _____

☐ Yes ☐ No Do you experience frequent headaches? How many per week/month? _____

☐ Yes ☐ No Are you pregnant? If yes, how many months? _____

☐ Yes ☐ No Do you have any allergies? Please list: _____

☐ Yes ☐ No Are you allergic to anything topically (skin)? Please list: _____

☐ Yes ☐ No Do you suffer from arthritis or joint swelling? If yes, what joints? _____

☐ Yes ☐ No Do you have osteoporosis?

☐ Yes ☐ No Do you suffer from TMJ syndrome or grind/clench your teeth?

☐ Yes ☐ No Do you have high blood high pressure? If yes, please list any medication(s): _____

☐ Yes ☐ No Do you suffer from epilepsy or seizures?

☐ Yes ☐ No Do you have cardiac or circulatory problems?

☐ Yes ☐ No Do you have varicose veins? If yes, please list location: _____

☐ Yes ☐ No Do you bruise easily?

☐ Yes ☐ No Do you have any history of either cranial (head) or sacral (tailbone) trauma/concussion? Date of injury? _____

☐ Yes ☐ No Any broken bones in the past? Please list: _____

☐ Yes ☐ No Do you suffer from back pain? If yes, is it in a specific area? _____

☐ Yes ☐ No Are you currently experiencing numbness in any area? Please list: _____

☐ Yes ☐ No Are any areas sensitive to pressure? Please list: _____

☐ Yes ☐ No Are you currently experiencing any muscle tension or soreness? List area(s): _____

_____

☐ Yes ☐ No Any injuries/trauma/surgeries? List type and date of occurrence: _____

_____

☐ Yes ☐ No Do you suffer from any chronic problems or have any other medical condition I should know about? Please list:

_____

_____

_____

List any medications you are taking, not mentioned above:_____

_____

Please read, initial and sign where indicated below

Please be advised of the policies for this office. Your signature below signifies acceptance of these policies.

Cancellation

A 24-hour notice is required for cancellation of an appointment, or you will be charged ***in full*** for the appointment. Payment is due before your next appointment.

Tardiness

Appointment times are as scheduled and cannot extend beyond the stated time to accommodate late arrivals.

Sickness/Injury

Manual therapy is not appropriate care for infectious or contagious illness (i.e.: poison ivy contact, common cold, influenza, covid, etc.), or after an acute injury (i.e.: car accident, sprain or broken bone, head trauma, etc.). Please cancel your appointment as soon as you are aware of an infectious or contagious condition and immediately after an acute injury. If it is within the 24-hour notice period, the cancellation fee may be waived.

Initials

_____ I understand that a combination of Swedish, Deep Tissue, Trigger Point, Myofascial Release, Hot Stone, Sports/Stretching, Reciprocal Inhibition, Neuromuscular Therapy, Reflexology, Manual Lymphatic Drainage, Thai, Myoskeletal Alignment, Aromatherapy, Electronic Percussion, Cupping, Gua Sha, PhysioKinetix, Neuromuscular Reprogramming, CranioSacral therapy, Prenatal & Postnatal, and Reiki applications MAY be used during the therapy session if applicable for my treatment plan.

_____ I understand that breast massage of female clients is not within the scope of practice for Frisco Massage Therapy and will not be performed.

_____ I understand that draping (including the genital area and gluteal cleavage) is required by the State of Texas and will be used during the entire massage session.

_____ I understand that I or my massage therapist may end the massage session if they feel uncomfortable for any reason.

_____ I understand that the massage therapist MUST immediately end the massage session if there is verbal or physical contact that is sexual in nature.

I understand that the massage/bodywork 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 during 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.

Client Signature_____ Date_____

Practitioner Signature_____ Date_____

Consent to Treatment of Minor:

By my signature below, I hereby authorize_____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent, as they deem necessary.

Signature of Parent or Guardian_____ Date_____

Practitioner Signature_____ Date_____