Bayside Acupuncture
Massage Client Information

Name: _____Phone: _____
Address: _____
City: _____State:_____Zip:_____
Email: _____
Home Phone: _____ Mobile Phone: _____
Date of Birth: _____ Occupation: _____
Referred by: _____
Emergency Contact: _____Phone #: _____

Have you ever received massage therapy? _____Yes_____ No
Type of massage experienced (swedish, shiatsu, deep tissue, etc.)_____
Are you currently taking any medications? _____Yes _____No
If yes, please list name and reason for medications_____
_____
_____
Are you currently seeing a healthcare professional? _____Yes _____No
If yes, please list names and reason/treatment_____
_____

Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.

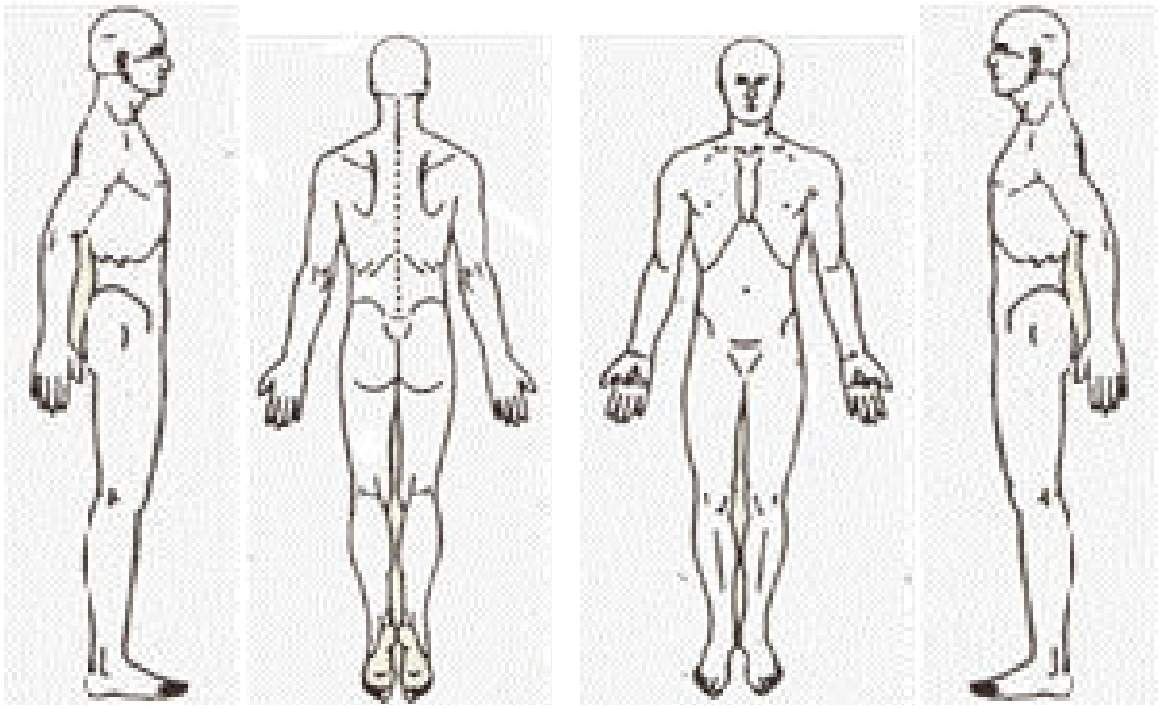
__arthritis
__blood clots
__bruise easily
__chronic pain
__auto-immune condition*
__skin conditions
__surgery
__Whiplash
__headaches
__back problems
__insomnia
__pregnancy
__seizures
__chemical dependency (alcohol, drugs)
__diabetes
__broken/dislocated bones
__cancer
__constipation/diarrhea
__hepatitis (A, B, C, other)
__stroke
__TMJ disorder
__diverticulitis
__heart conditions
__high blood pressure
__muscle strain/sprain
__scoliosis
__ depression, panic, or other pysch condition

(*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

If any of the above needs to be detailed or if there is anything else to share, please do so: _____
Do you have any of the following today:
_____skin rash _____cold/flu_____ open cuts _____severe pain
_____anything contagious _____injuries/bruises
Do you have any allergies to:
_____ medications _____foods (nuts, etc.)
_____ environmental allergens (dust, pollen, fragrances)
_____ reactions to skin care products

If any of the above are checked, please give details: _____

Are you wearing: _____ contact lenses _____ hearing aid _____ hairpiece
Please indicate with an (X), if any, the areas in which you are feeling discomfort:



What are your goals/expectations for this therapy session? _____
_____

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to:
*need to move or change position * sighing, yawning, change in breathing
stomach gurgling * emotional feelings and/or expression
movement of intestinal gas * energy shifts * falling asleep * memories

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that
I have answered all questions pertaining to medical conditions truthfully and give consent to be treated.

Signature: _____Date: _____