CLIENT INFORMATION

Cathy Smith, MBA ND LMT
9116 Dorothy Ln - St Francisville LA 70775
(225) 784 - 2168

Arrival:_____ End:_____

To maximize the effectiveness and safety of your massage sessions, please take time to carefully complete this questionnaire. If you prefer not to answer a question, please draw aline through it. This information will be treated confidentially and will not be shared with anyone except by your permission and signature on an Authoirization to Release Information form.

Name _____ Phone ( ) _____
Address _____
City _____ State _____ Zip _____
Email _____ Date of Birth _____
Occupation _____ Referred By _____
Emergency Contact _____ Emergency Phone _____

Pain/Stress: Pre- & Post-Treatment Measures

Please indicate pain and stress levels BEFORE and AFTER massage:

	BEFORE	AFTER
Pain level: 0=none; 5= moderate; 10=severe		
Stress level: 0=none; 5= moderate; 10=severe		

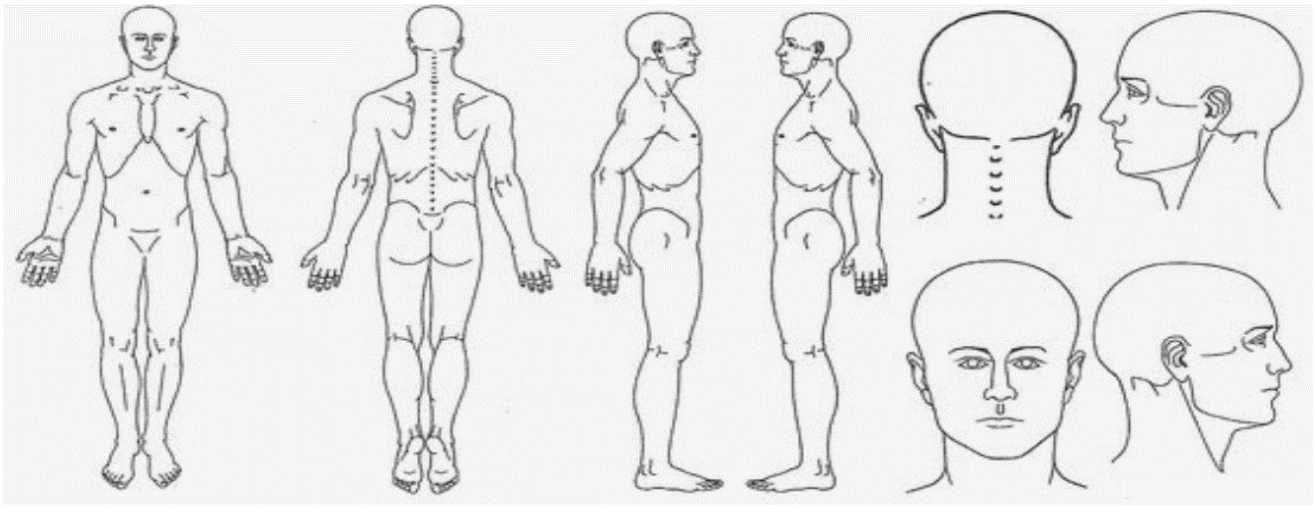
What Are Your Goals For Today? (Check Only ONE)

◯ Yes ◯ No • Do you want to get at the cause of your discomfort and find a permanent solution?
◯ Yes ◯ No • Do you want sympotamic relief so you can function better?
◯ Yes ◯ No • Are you OK with how your body is feeling & just want to do something nice for youself today?

Medical History (Please check all that apply)

◯ Hypertension
◯ Herniated Disc
◯ Fibrocystitis
◯ PMS / Painful Mensturation
◯ Thrombosis/Embolism/Stroke
◯ Epilepsy
◯ Osteo and/or Rheumatoid Arthritis
◯ Phlebitis
◯ Chronic Fatigue
◯ Pregnancy
◯ Balance Problems
◯ HIV/AIDS
◯ Cancer/Malignancy
◯ Edema (Swelling)
◯ Balance Problems
◯ Inflammation
◯ Allergies
◯ Skin Sensitivity
◯ Diabetes
◯ Skin Rashes
◯ Fibromyalgia
◯ Headaches
◯ Osteoporosis
◯ Heart Disease
◯ Varicose Veins
◯ Abscess or Open Sore(s)
◯ Other_____

Mark Areas to Show Location of Problems:



Medical and Surgical Information

◯Yes ◯No Do you have any areas of concern?

If YES, please explain: _____

◯Yes ◯No Do have any areas you want avoided?

If YES, please explain: _____

◯Yes ◯No Do you have any allergies (cremes, lotions, etc.)?

If YES, please explain: _____

◯Yes ◯No Have you had any recent surgeries?

If YES, please explain: _____

◯Yes ◯No Do you experience any difficulty lying face up or face down?

◯Yes ◯No Do you have musculoskeletal pain/stiffness (e.g.: lower back, neck, shoulder, feet, etc.)?

If YES, please explain: _____

◯Yes ◯No Do you have any other physical or emotional issues?

If YES, please explain: _____

◯Yes ◯No Do you wear contact lenses? ◯Yes ◯No Do you wear a hearing aid?

◯Yes ◯No Are you under medical care or supervision at this time?

If YES, for what condition(s)? _____

◯Yes ◯No Have you taken any over-the-counter medications today?

If YES, what & when? _____

◯Yes ◯No Have you taken any prescription medications today?

If YES, what & when? _____

◯Yes ◯No Do you take vitamins/herbs on a regular basis?

If YES, what & when? _____

◯Yes ◯No Do you grant permission for your chosen medical professional to be contacted should the need arise?

Name of Provider: _____ Phone: _____

PLEASE READ THE FOLLOWING INFORMATION AND SIGN WHERE INDICATED.

While massage has numerous benefits, there are inherent massage-related risks, such as bruising, increased pain, or soreness lasting a few days, which do not disrupt activities of daily living. However, there are also reported rare, harmful effects from massage such as damage to nerves, glands, organs, and blood vessels. To reduce these risks:

- I have stated all known medical conditions and answered questions honestly;
- I will keep the massage practitioner updated as to any changes in my health; and
- I will promptly communicate any pain or discomfort experienced during this session.

I understand massage should not be construed as a substitute for medical examination and I should consult an appropriate health care provider for mental or physical ailments. I further understand massage practitioners are not qualified to perform spinal manipulations, diagnose, or prescribe. Finally, I understand any illicit or sexually suggestive remarks or conduct will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. I have read and agree to comply with all above terms, and consent to treatment acknowledging above stated risks.

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date

Information and Suggestions for Client

- ☑ Prior to massage, remove all jewelry and glasses, if applicable. Pull long hair back with a clip.
- ☑ AMMA massage is provided while you are fully clothed but remove shoes.
- ☑ Other types of massage require disrobing but leaving panties/shorts on.
- ☑ Any appointment cancelled same day is subject to full charge of the appointment.