

Welcome to Empowered Healing! I would like to make your appointment as pleasant and comfortable as possible.
 If at any time you have questions regarding your session, please let me know! I look forward to taking excellent care of you!

Personal Information

Name _____ Home phone _____ Cell phone _____
 Address _____ City _____ State _____ Zip _____
 Email address _____ Date of Birth ____/____/____ Age _____
 Occupation _____ Type of Exercise _____ Rate your posture: Excellent Good Fair Poor
 Have you ever received a professional massage? Y / N Types of massage experienced? Swedish / Deep Tissue / Thai / Other _____
 Are you taking medications? Y / N If yes, please describe _____
 Are you pregnant? Y / N If yes, how many weeks? _____ High risk? Y / N If yes, please explain _____
 Pressure preference? 1 2 3 4 5 6 7 8 9 10 (1 being lightest / 10 being deepest)
 Any difficulty laying on your back, front or side? Y / N If yes, describe _____
 Allergies to essential oils? Y / N Please list _____ Allergies to perfumes or other lotions/oils? Y / N Do you have sensitive skin? Y / N
 Do you sit for long hours at a workstation, computer, or driving? Y / N
 If yes, please describe _____
 Do you perform any repetitive movement in your work, sports, or hobby? Y / N
 If yes, please describe _____

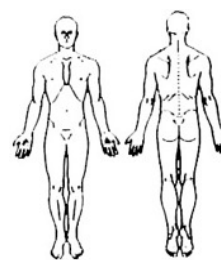
Medical History

Are you currently under medical supervision? Y / N If yes, please explain _____
 Do you see a chiropractor? Y / N If yes, how often? Weekly Monthly Just when something hurts

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- | | |
|---|--|
| <input type="checkbox"/> headaches/migraines | <input type="checkbox"/> contagious skin condition |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> easy bruising |
| <input type="checkbox"/> back/neck problems | <input type="checkbox"/> recent accident or injury |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> recent fracture |
| <input type="checkbox"/> TMJ | <input type="checkbox"/> deep vein thrombosis/blood clots |
| <input type="checkbox"/> carpal tunnel syndrome | <input type="checkbox"/> open sores or wounds |
| <input type="checkbox"/> tennis elbow | <input type="checkbox"/> phlebitis |
| <input type="checkbox"/> cancer | <input type="checkbox"/> joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis |
| <input type="checkbox"/> decreased sensation | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> surgery | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> mastectomy | <input type="checkbox"/> heart disease |
| <input type="checkbox"/> breast augmentation | |

	Please indicate your consumption level:			
	None	Light	Moderate	Heavy
Sugar	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
WATER	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____



Please indicate with an 'X' areas of discomfort

Please read the following information and sign below:

- 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.
- This is a therapeutic massage and any sexual remarks or advances will terminate the session and I (client) will be liable for payment of the scheduled treatment.
- Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.
- I am responsible for paying for any appointment cancellations of less than 24 hours.

Signature: _____ Date: ____/____/____ Referred by: _____

