3425 Bee Caves Rd. Ste B-2 West Lake Hills, TX 78746

Massage & Bodywork Client Information & Consent Form

Name ____________________ **D.O.B** ____________

Address ____________________ **City** ____________________

State ______ **Zip** ____________ **Mobile** ( ) ____________

Email ____________________ **Referred by:** ____________________

Occupation ____________________

MEDICAL INFORMATION: *If you have a specific medical condition, massage/bodywork may be contraindicated and could require doctor's approval. Please indicate if you have ever been diagnosed with any of the following conditions listed below:*

☐ Past ☐ Current	**Allergies**	☐ Past ☐ Current	**Hepatitis**
☐ Past ☐ Current	**Arthritis/Joint Swelling**	☐ Past ☐ Current	**High Blood Pressure**
☐ Past ☐ Current	**Asthma**	☐ Past ☐ Current	**High Cholesterol**
☐ Past ☐ Current	**Back Pain/Spinal Condition**	☐ Past ☐ Current	**Lupus**
☐ Past ☐ Current	**Bursitis**	☐ Past ☐ Current	**Multiple Sclerosis**
☐ Past ☐ Current	**Blood Disorder**	☐ Past ☐ Current	**Nerve Damage**
☐ Past ☐ Current	**Bruise easily**	☐ Past ☐ Current	**Osteoporosis**
☐ Past ☐ Current	**Cardiac/Circulatory problems**	☐ Past ☐ Current	**Pacemaker**
☐ Past ☐ Current	**Cancer**	☐ Past ☐ Current	**Seborrhea**
☐ Past ☐ Current	**Carpal Tunnel Syndrome**	☐ Past ☐ Current	**Seizures/Epilepsy**
☐ Past ☐ Current	**Cystic Fibrosis**	☐ Past ☐ Current	**Skin Condition**
☐ Past ☐ Current	**Claustrophobia**	☐ Past ☐ Current	**Stroke**
☐ Past ☐ Current	**Diabetes**	☐ Past ☐ Current	**Tendonitis**
☐ Past ☐ Current	**Fibromyalgia**	☐ Past ☐ Current	**TMJ Syndrome**

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(Over)

☐ Past ☐ Current	**Headaches/Migraines**	☐ Past ☐ Current	**Varicose Veins**
☐ Past ☐ Current	**Heart Condition/Disease**	☐ Past ☐ Current	**Other**
☐ Past ☐ Current	**Hemophilia**	Please explain: ______________________________	

Overall Stress Level: [ ] Low [ ] Medium [ ] High

Are you currently being treated by a physician? List treatments/medications you are taking to address any health conditions: ____

List any nutritional supplements you are presently taking: ______________________________
____

List any recent injuries, accidents, or surgeries:
____

Do you exercise regularly? [ ] Yes [ ] No Are you pregnant? [ ] Yes [ ] No
If so, how far along are you? ____

Have you had a professional massage/bodywork session before? [ ] Yes [ ] No
If yes, how recently? ____________ What kind of pressure do you prefer? ____________

Please take a moment to carefully read the following information and sign where indicated.

*I, the undersigned, 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 the 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/bodywork shouldn't be construed as a substitute for a 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 course of the given session should be construed as such. Because massage/bodywork and body wraps 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 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 if I make any illicit or sexually suggestive remarks or advances, it will result in immediate termination of the session. I will also be liable for payment in full of my scheduled appointment. I relieve **Spa La La/Coraly Serrano** from any liability resulting from an adverse reaction to any of the services provided.*

Client Printed Name ______________________________ **Date** ______________

Client Signature ______________________________ **Date** ______________

Practitioner Signature ______________________________ **Date** ______________

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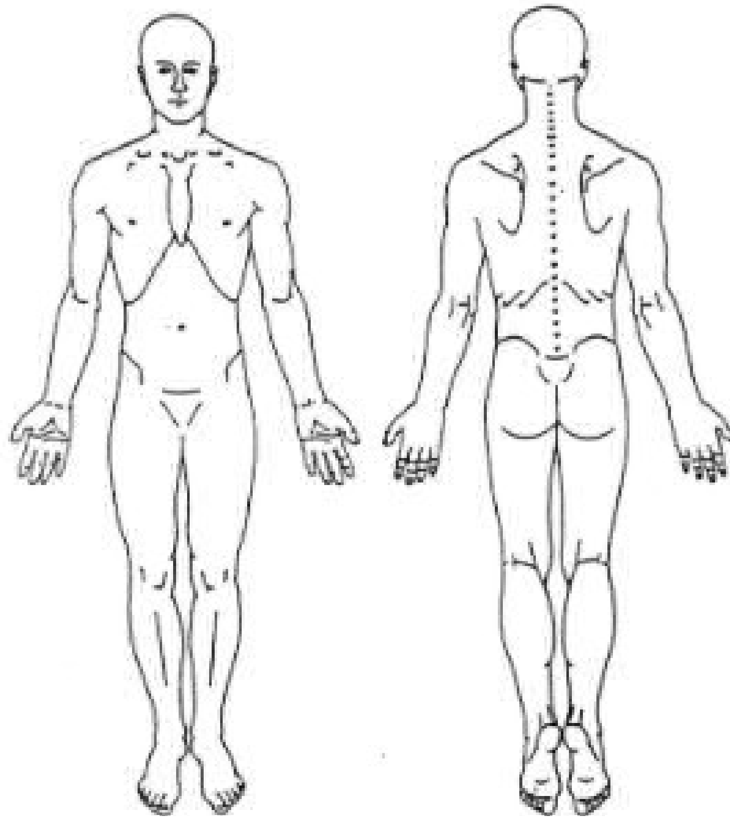
Body Diagram

Instructions: On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition.



Indicate on the line below how you would describe your present pain by placing a mark on the line between the two extremes of no pain at all vs. the worst pain you have ever felt.

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