Relaxation and Rehabilitation Massage Therapy, Suite 120 Oberlin Inn, Oberlin, OH 44074

Client Information

Name:_____Telephone:(____)_____Date of Birth:_____

Address:_____City:_____State:____ Zip:_____

Referred by:_____Telephone: (___)_____

In case of emergency:_____Telephone:(___)_____

General & Medical Information

Occupation:_____Age:____male _female Physician:_____

Health Insurance Carrier:_____

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.

_Yes _No Have you ever experienced a professional massage or bodywork session? How recently?_____

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

_ Yes _ No Do you frequently suffer from stress?
_ Yes _ No Do you have diabetes?
_ Yes _ No Do you experience headaches?
_ Yes _ No Are you pregnant?
_ Yes _ No Do you suffer from arthritis?
_ Yes _ No Are you wearing contact lenses?
_ Yes _ No Are you wearing dentures?
_ Yes _ No Do you have high blood pressure?
_ Yes _ No If 'yes' to previous question, are You taking medication for this?
_ Yes _ No Do you suffer from epilepsy or seizures?
_ Yes _ No Do you suffer from joint swelling?
_ Yes _ No Do you have varicose veins?
_ Yes _ No Do you have any contagious diseases?
_ Yes _ No Do you have osteoporosis?
_ Yes _ No Do you have any allergies?

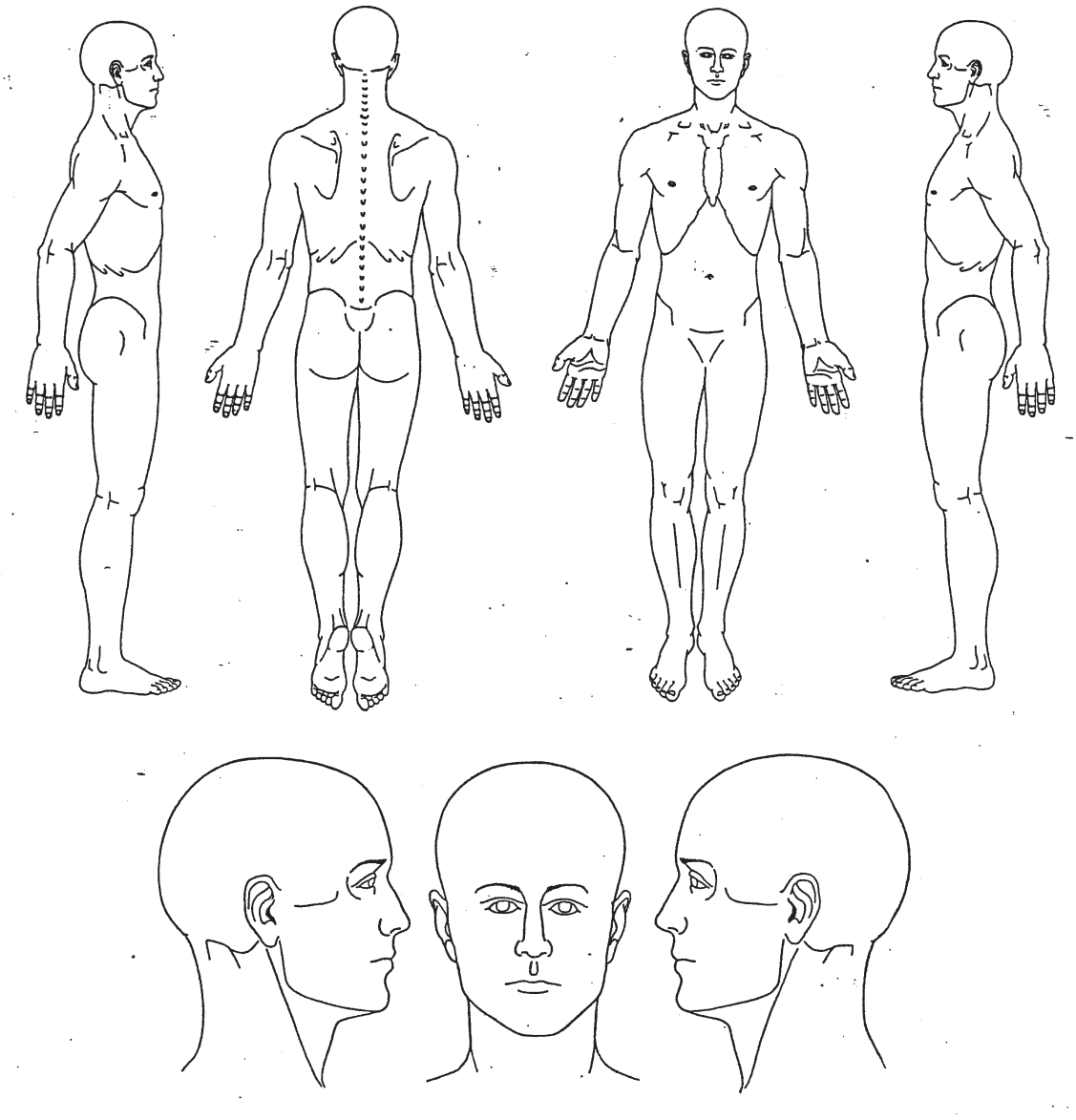
_ Yes _ No Do you bruise easily?
_ Yes _ No Have you had any broken bones in the past two years?
_ Yes _ No Have you been in an accident or suffered any injuries in the past two years?
_ Yes _ No Do you have tension or soreness in a specific area? Please specify:_____
_____
_ Yes _ No Do you have cardiac or circulatory problems?
_ Yes _ No Do you suffer from back pain?
_ Yes _ No Do you have numbness or stabbing pains anywhere?
_ Yes _ No Are you very sensitive to touch or pressure in in any area?
_ Yes _ No Have you ever had surgery? Explain below.
_ Yes _ No Do you have any other medical condition or are you taking any medications I should know About?

Comments:_____
_____
_____

Please complete page 2.

THERAPIST NOTES: _____
_____
_____

WITH RED PENCIL, COLOR THE AREAS WHERE YOU'VE HAD PAIN LATELY:



I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular or soft tissue tension or pain. If I experience any pain or discomfort during this session, I will immediately inform the therapist 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 therapists are not qualified to perform spinal or skeletal adjustments or diagnose or prescribe for physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage therapy 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 therapist 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. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature _____**Date**:_____

Therapist 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:_____