

Featherstones



Therapeutic Massage

Massage Registration

Name _____ M/F

Address _____

City/State/Zip _____

Home Phone _____ Work Phone _____

Date of Birth _____ Cell Phone _____

Referred by _____

What do you do for work? _____ Email _____

Have you ever experienced professional massage/bodywork? _____

Do you have or have you had any of the following (check all that apply):

Frequent Stress

Frequent Headaches

Are you pregnant

Are you wearing contact lenses

Are you taking any medications

Are you allergic to oils or perfumes

Back Pain

Numbness or stabbing pains

Tension or soreness in a specific area

Swollen Legs

Injuries to back, knees, ankles

Are you sensitive to touch/pressure

Any skin disorders

Rheumatic fever

High or low blood pressure

Heart trouble

Rhythm Abnormalities

Stroke or Heart Attack

Cardiac or circulatory problems

Chest Pains

Shortness of breath

Heart Palpitations

Light-headedness

Disease of Arteries

Varicose Veins

Epilepsy

Diabetes

Operations

Lung Disease

Cough on Exertion

Coughing up blood

Awaken short of breath

Loss of Consciousness

Have you ever had any broken bones

Do you have any other medical condition

Are you currently being treated by a doctor,
chiropractor or other healing practitioner

If you checked any of the above, please explain _____

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. I 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 a 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 the massage/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 that I am aware of. I understand that massage/bodywork 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 as to any changes in my medical profile and understand that there shall be no liability on the practitioner's or facility's part should I forget to do so. **Please respect our 24 hour cancellation policy.**

Client Signature _____ Date _____