oh! optimum health
THERAPEUTIC MASSAGE

NAME_____

ADDRESS _____ city/state/zip_____

EMAIL_____ Date of Birth _____

REFFERED BY _____ OCCUPATION _____

Phone #_____

Do you have any allergies to oils,lotions,fruits or nuts? _____

Have you had a professional massage before? _____

What results are you looking for from this session? _____

Are you currently taking any medication? _____

Have you ever had a blood clot? _____

Please list surgeries _____

Anything medically we should be aware of? _____

Do you see a chiropractor? Name _____

Exercise? _____

I understand that the massage I receive is provided for the purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort. I further understand that I should see a physician or other qualified medical specialist for any ailment that I am aware of. I understand that massage therapists are not qualified to perform adjustments, diagnose, prescribe, or treat any physical or mental illness. Because massage 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 therapists part should I fail to do so.

Signature of client _____ Date _____