Alison Todd, LMT, NTS

Client Information

Name: ______________________ Date: ______________________

Address: ______________________ Phone: ______________________

______________________ DOB: ______________________

Email: ______________________ Occupation: ______________________

Emergency Contact: ______________________ Phone: ______________________

How did you hear about us? ______________________

Massage/Bodywork Experience and Preferences

Have you had bodywork before? Yes No

What are your goals for treatment? ______________________

Are you sensitive to pressure in any areas? Yes ______________________ No

What is your preferred amount of pressure (if known)? Light Medium Hard

Are you sensitive to fragrances or perfumes? Yes No

What are your common areas of pain and/or tension? ______________________

Health History

Have you had a history of any of the following? (circle)

Abdominal Pain	Communicable Disease	Neck Pain
Accident	Decreased Range of Motion	Nervous Tension
Anxiety/Depression	Diabetes	Sciatica
Arthritis/Bursitis/Gout	Fibromyalgia	Scoliosis
Asthma	Headaches/Migraines	Seizures
Back Pain	Heart Attack	Shoulder Pain
Blood Clots	High/Low Blood Pressure	Sprains
Broken Bones	HIV	Stroke
Cancer/Tumors	Joint Ache	Surgery
Carpal Tunnel	Lymph Node Removal	Varicose Veins
Colitis	Masectomy	Whiplash

Please explain circled responses and list any other ailments missing from above:

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Do you exercise regularly and/or participate in any sports? Yes No

If yes, describe: ____

Do you experience stress in your work, family, or other aspect of your life? Yes No

If yes, describe: ____

Have you recently had any injury, inflammation, or surgery? Yes No

If yes, describe: ____

Please list any current medications: ______________________________

Please list any known allergies: _________________________________

Are you currently pregnant? Yes No If yes, how far along? __________

Have you consumed alcohol in the last 24 hours? Yes No

Client Contract for Care (initial each and sign)

Would you like a reminder 24 hours before each appointment? Yes No

Preferred method of contact? Phone Text Email

_______ If I am unable to cancel an appointment within 24 hours notice, I may be charged for the full price of my treatment.

_______ If I am late for an appointment, the treatment will still end at the allotted time.

_______ I understand that this is a non-sexual treatment and no sexual activity, comment, or innuendo will be tolerated. Both the therapist and the client have the right to end the treatment at any time, for any reason.

_______ I acknowledge that massage therapy is not a substitute for medical care or diagnosis. I have stated all medical conditions that I am aware of and will inform my therapist of any changes in my health status.

_______ I will participate fully as a member of my healthcare team and make sound choices regarding my session plan based on the information provided by my massage therapist. I agree to participate in my own self-care programs and to communicate with my therapist any time I feel my well-being is being compromised.

_______ I have read the Notice of Privacy Practices provided to me by my therapist.

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Signature of Client/Parent/Guardian Date