Body Speak LLC

Therapeutic Massage/ANF Therapy/Yoga

MT113388

CLIENT INFORMATION AND CONSULTATION FORM

NAME:		DATE OF BIRTH:	
HOME ADDRESS, CITY, STATE, ZIP CODE:			
PHONE:	HOME:	WORK:	CELL:
EMAIL:			
EMERGENCY CONTACT:			
OCCUPATION:			
Have you had professional therapeutic massage before?	YES if yes how long ago?	NO	

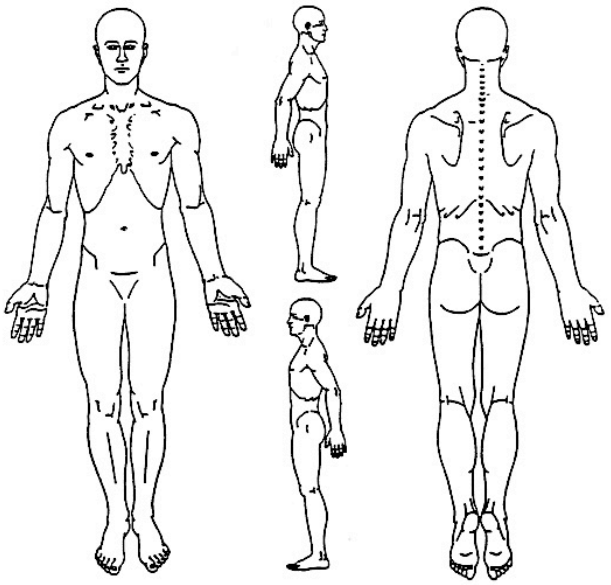
ANSWER THE FOLLOWING WITH YES OR NO & EXPLAIN IF NECESSARY

Allergies:	Diabetes:
Arthritis:	High/Low Blood Pressure:
Blood Clots:	Pregnant: Due Date:
Cancer:	Seizures:
Circulation Disorders:	Skin Problems:
Contact Lenses:	Varicose Veins:
Contagious Diseases:	Digestive Issues:
List all current medications:	
List any other **medical conditions, major illness**, **broken bones**, **surgeries**, or **accidents** that you have had within the last 3 years:	

ON THE DIAGRAM TO THE RIGHT

CIRCLE the areas of the body **that** you feel **need** the most **attention** in the massage session:

PLACE an X over the areas that you wish to have avoided:



Please Turn Over to Complete Page 2

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PLEASE READ & INITIAL THE FOLLOWING STATEMENTS

1	I am aware that draping will be used during the therapeutic massage session.	
2	Breast massage is not performed on female clients without written consent of the client prior to the therapeutic massage session. Access to the sternum and area around the groin may be necessary during the therapeutic session to assess and provide treatment.	
3	Therapeutic Massage, Amino Neuro Frequency (ANF) Therapy, Yoga is for the sole purpose of stress reduction, relief from muscle tension or spasm and to increase circulation and energy flow.	
4	I understand that the Massage Therapist does not diagnose, prescribe medical treatments or pharmaceuticals, and does not perform any spinal adjustments.	
5	Therapeutic Massage, ANF Therapy, Yoga, is not a substitute for medical examination or diagnosis. If I have any serious medical diagnosis / injury I may be required to provide a physicians written consent prior to services.	
6	It is my (the Client), responsibility to explain and discuss all physical conditions with the Massage Therapist so that they may do their job.	
7	I understand that my (the Client), feedback is an essential element in my treatment, therefore if at any time I or the Massage Therapist should become uncomfortable during the massage, I or the Therapist may ask to end the massage session, and the session will end.	
8	I understand that If I choose to have Cupping or any instrument assisted soft tissue mobilization as part of my therapeutic massage session that discoloration/broken capillaries, tenderness, redness and/or itching may be a result of treatment.	

9	If I am unable to keep an appointment, I understand that a 24 hour notice is required, otherwise I will be charged for the time reserved.	
10	If I forget or consciously choose to forgo my appointment for any reason, I will be considered a “no show” and agree to be charged the full amount of my scheduled time.	
11	If I arrive late, my session may be shortened in order to accommodate others whose appointments follow mine. Depending upon how late I arrive, my Therapist will then determine if there is enough time remaining to start a session. Regardless of the length of time actually given I will be responsible for the full cost of the session.	

I have read and I fully understand this form in its entirety. If at any time there are changes in the information given or in my condition, I will notify my Therapist and update this form before receiving additional therapies. **If I am under the age of 17 I will provide written consent of parent or guardian to receive massage.**

Client Signature: _____ Date:_____
(**Parent or Guardian if under age 17)**

Therapist Signature:_____ Date:_____

TO BE COMPLETED BY MASSAGE THERAPIST

Type of Massage Techniques to be implemented	
Parts of body to be massaged	
Indications/Contraindications	