∞ Deeply Devoted Massage ∞

The Art of Touch, the Science of Healing.

Your answers to these questions are kept confidential and seen only by your therapist.
Knowing you, and your body, will help us provide you with the best care possible!

Client Name: **Date of Birth:**

Address:

City: **State:** **Zip:**

Telephone: **E-Mail:**

What type of work do you do? _____
What do you do to relax? _____
How is your body feeling today? _____

How would you characterize your frequency of massage? Never Rare Occasional Habitual

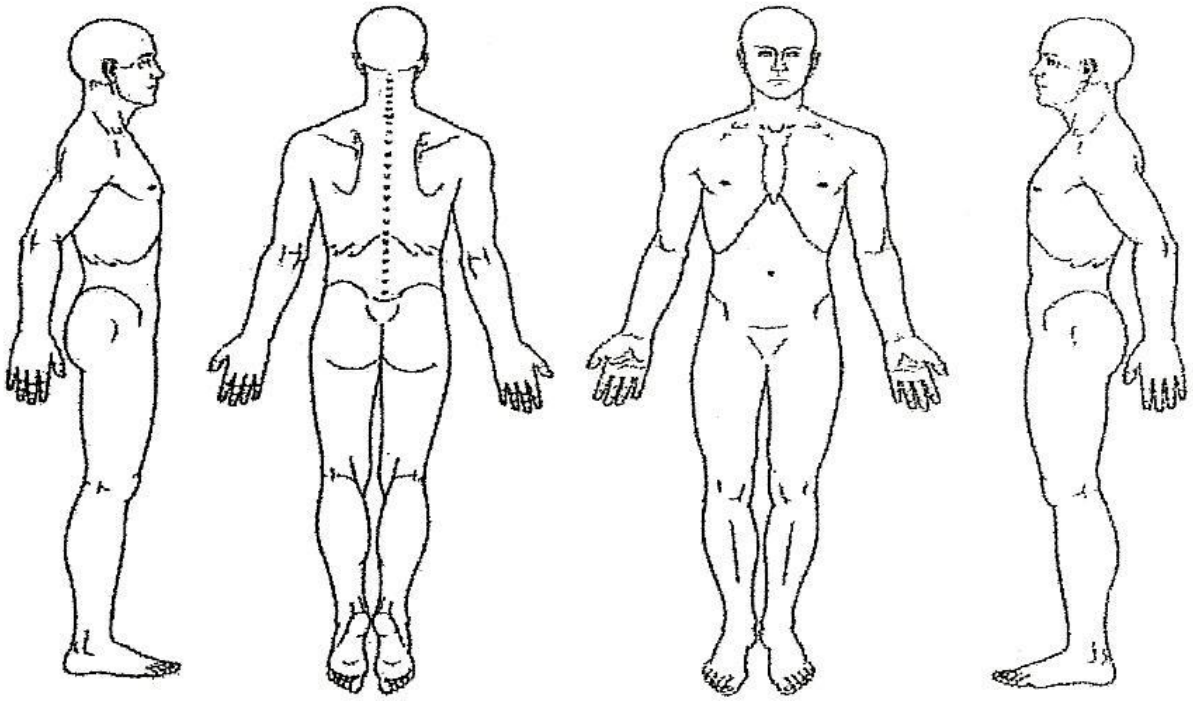
What would you like from your session today? (please circle all that apply)

Relaxation/Stress Reduction Pain Relief Injury Recovery (date of injury: _____)

Increased Body Awareness To Feel Good! Other _____

Are any areas of your body feeling stiff/sore/achy or uncomfortable? _____

Please place a √ on the areas you would like me to focus, and an × on any areas I should avoid.



538 W. State Street Ithaca, New York 14850 607.592.3316 deeplydevoted@gmail.com
www.deeplydevotedmassage.com

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Are you currently seeing a health care professional? _____ Yes _____ No
If yes, please list name(s) and reason/treatment: _____

Are you currently taking any medications? _____ Yes _____ No
If yes, please list name and reason for medication: _____

Are you currently pregnant? _____ Yes _____ No If yes, when is your due date? _____

Have you recently experienced any life changing events? _____

Do you have any of the following today?

- ☐ Skin Rash
- ☐ Cold/Flu
- ☐ Open Cuts
- ☐ Severe Pain
- ☐ Anything Contagious
- ☐ Injuries/Bruises

Do you have any allergies to:

- ☐ Medications
- ☐ Foods
- ☐ Environmental Allergens
- ☐ Reactions to Skin Care Products

If any of the above are checked, please give details: _____

Are you wearing: _____ Contact Lenses _____ Dentures _____ Hearing Aid _____ Hair Piece

Please review the following list and check those conditions that have affected your health either recently or in the past.

- ☐ Arthritis (where: _____)
- ☐ Anxiety and/or Panic Disorder
- ☐ Auto-Immune Conditions:_____
- ☐ Back Pain/Problems. Herniated discs?_____
- ☐ Chemical Dependency
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis, Irritable Bowel, Crohn's Disease
- ☐ Blood Clots
- ☐ Broken Bones (where/when:_____)
- ☐ Bruise Easily
- ☐ Cancer. Type:_____ In Remission?____
- ☐ Chronic Pain (where: _____)
- ☐ Constipation/Diarrhea
- ☐ Headaches/Migraines. How often? _____
- ☐ Heart Conditions: _____
- ☐ Hepatitis (A, B, C, other)
- ☐ High Blood Pressure. Regulated? ___Yes ___No
- ☐ Insomnia
- ☐ Kidney Disease: _____
- ☐ Muscle Sprain/Strain (where/when: _____)
- ☐ Scoliosis
- ☐ Seizures
- ☐ Skin Conditions
- ☐ Stroke (when: _____)
- ☐ Surgery (where/when: _____)
- ☐ TMJ Disorder
- ☐ Whiplash (when: _____)

The therapist and client must openly communicate about any issues that may affect the client's treatment and responsiveness to treatment; it is important the client let the therapist know of any known issues, and also of any changes that may affect treatment. The services provided are not a replacement for medical or psychological care. Any information we provide is not prescriptive or diagnostic in nature, and is intended only to educate. In order to provide the client with the best and most appropriate treatment, we may discuss information pertinent to the client's condition(s) with associated LMTs, and/or with the health care providers the client has listed above.
Please indicate that you understand and consent to the above by signing and dating below.

Client Signature: Date:

THERAPIST: _____

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