Carol Kennedy Massage Therapy

Client Information

(please print)

Name:____ **Date**___________

Address:____

City:______________________________ **State:**__________ **ZIP**____________

Phone: (1st)______________________ **(2nd)**__________________________________

Email (specials and reminders)____

(I promise not to sell your name in any way shape or form)

Occupation_________________________ **Referred by**___________________________

Date of Birth ______/______/______

Patient Background Information

Have you ever received a professional massage? No_____ Yes_____ When? ________

Are you pregnant or trying you become pregnant? No_____ Yes_____

Please review this list and circle any illnesses and/or medical conditions that apply:

diabetes	contact lenses	ruptured/bulging disc
arthritis	heart condition	elevated cholesterol
seizures	skin disorder	high blood pressure
cancer	varicose veins	infectious conditions
stroke	phlebitis	autoimmune disorder
headache	scoliosis	previous MVA/trauma
tingling	loss of balance	fatigue/depression
bruxing/grinding teeth	bruising	painful joints

Additional client remarks/comments ____

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Because a massage therapist must be aware of any existing physical conditions that I have, I have listed all of my known medical conditions and physical limitations and will inform the massage therapist in writing of any changes in my physical health. I understand that a massage therapist neither diagnoses illness, disease, or any other medical, physical, or emotional disorder, nor performs any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailment that I have. I also agree to give 24 hour notice if I must cancel my appointment for any reason.

Signed ____ *Date* _____ / _____ / _____

Consent for minor: I, the undersigned, grant the massage therapist permission to give my son/daughter a massage.

Signed by Parent/Guardian ________________________________ *Date* _____ / _____ / _____