Tea Massage

Initial Client Entrance Form

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Phone _____

Date of Birth (dd/mm/yy) _____

Occupation _____

Emergency Contact/Relationship _____ Contact Phone _____

Have you ever received a professional massage before? ❒Y ❒N

If yes, for what reason?

❒ Wellness /Relaxation

❒ Clinical – To work on specific symptoms/pain relief

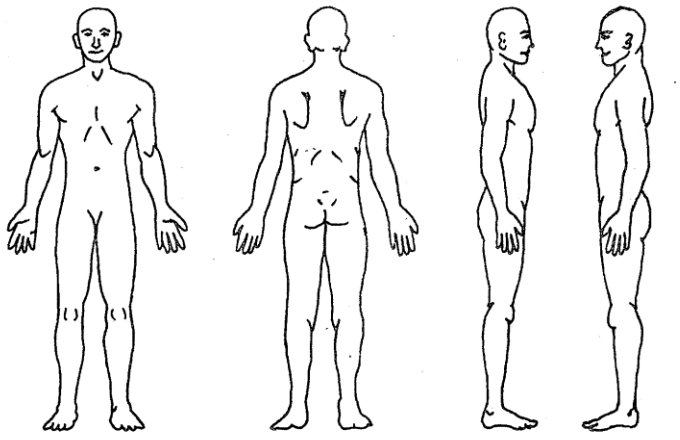
When was your last massage? _____

What are your goals for today's treatment? _____

_____

Are you sensitive to touch or pressure in area? _____

Please indicate areas you are experiencing pain/discomfort on the diagram below:



Habits/Lifestyle

Tobacco use	❒high	❒moderate	❒low	❒n/a
Drug/alcohol use	❒high	❒moderate	❒low	❒n/a
Sugar use	❒high	❒moderate	❒low	❒n/a
Exercise	❒high	❒moderate	❒low	❒n/a (# of times/week)
Sleep per night	❒ less than 4 hours	❒4-6	❒6-8	❒ 8+

Medical History

Are you currently under the care of a physician for any specific condition? ❒Y ❒N

Are you currently taking any medications? ❒Y ❒N

If yes, please provide type and reason _____

Do you have any allergies? ❒Y ❒N

If yes, please list _____

Are you allergic to nut based oils? ❒Y ❒N

Describe any surgeries you have had _____

Describe any accidents you have had _____

Any broken bones in the past two years? ❒Y ❒N

If yes, which bones?_____

Please select any of the following conditions that apply to you

Musculoskeletal
- ❒ arthritis/gout
- ❒ tendonitis/bursitis
- ❒ jaw pain/TMJ
- ❒ hernia
- ❒ osteoporosis

Respiratory
- ❒ chest pain
- ❒ difficulty breathing
- ❒ asthma
- ❒varicose veins

Skin
- ❒ bruise easily
- ❒ rash
- ❒ hives/allergies
- ❒ enlarged glands
- ❒ boils

Eyes, Ears, Nose & Throat
- ❒ colds/flu
- ❒ ear aches/infection/ringing
- ❒ sinus infection

Circulatory/Cardio-Vascular
- ❒ heart condition
- ❒ blood clots
- ❒ high/low blood pressure
- ❒ rapid/slow heart beats
- ❒ thrombosis/embolism
- ❒ swelling of ankles

Gastrointestinal
- ❒ irritable bowel syndrome
- ❒ bladder/kidney ailment
- ❒ Crohn's disease
- ❒ colitis
- ❒ ulcers
- ❒ liver trouble
- ❒gall bladder trouble

Urinary/Reproductive
- ❒ blood in urine
- ❒ kidney infection
- ❒ painful urination
- ❒ prostate trouble
- ❒ ovarian/menstrual problems
- ❒ pregnant ❒Y ❒N

(if yes, please fill out additional form)

Neurological
- ❒ pinched nerve
- ❒ paralysis
- ❒ shingles
- ❒ numbness/tingling
- ❒ dizziness
- ❒ headaches
- ❒ fainting
- ❒ chronic pain
- ❒ multiple sclerosis
- ❒ Parkinson's disease

Psychological
- ❒ anxiety/stress syndrome
- ❒ depression

Other
- ❒ cancer/tumors
- ❒ diabetes
- ❒ Any other medical condition (s)

_____

Please explain any of the conditions selected:

_____

_____

_____

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. I understand that the massage I receive is based on the information provided to the massage therapist by me. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that licensed massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. 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 massage therapist updated as to any changes in my medical profile during today's and all future sessions, and understand that there shall be no liability on the massage therapist's part should I fail to do so. I understand that all children under the age of 17 will be accompanied by an adult. Tea Massage is dedicated to providing a safe and comfortable environment for massage. Please be advised that you will be draped at all times during the massage. Upon the occurrence of any illicit or sexually suggestive behavior the massage will be immediately terminated, and there will be no refund.

I also understand that the License Massage Therapist reserves the right to refuse to perform massage on anyone whom she/he deems to have a condition for which massage is contraindicated. I agree to keep my massage therapist updated on any changes in my medical profile and understand that there is no liability on the part of the therapist should I neglect to do so.

I have read and understand the above guidelines and agree to abide by them.

Client Signature: _____Date _____

Practitioner Signature: _____Date_____

Consent to treatment of Minor: By my signature below, I hereby authorize **Tahirih Klass** to administer massage, or bodywork techniques to my child or dependent as they deem necessary.

Signature of Parent/Guardian:_____Date_____