BALANCING TOUCH

MASSAGE THERAPY AND ENERGY WORK

Trina Pinkney, LMT, RMT

Application for Therapeutic Massage and/or Energy Work

This questionnaire is designed to help me in providing you with the best professional care and service. The information provided is kept strictly confidential. Please read and fill in this form thoroughly, printing clearly.

Name: _____ Date: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Email: _____ Cell Phone: _____

Date of Birth: _____ Occupation: _____

Emergency Contact: _____ Emergency Contact's Phone: _____

Referred by: _____

Is this your first massage ☐ *Yes* ☐ *No* How would you rate your current state of health? ☐ *Excellent* ☐ *Good* ☐ *Fair* ☐ *Poor*

Are you currently under the care of a physician ☐ *Yes* ☐ *No* If *Yes*, please explain: _____

Are you currently taking ANY medications (*pain meds, narcotics, anti-inflammatories, muscle relaxants, or corticosteroids*)? ☐ *Yes* ☐ *No*

If *Yes*, please explain: _____

Please list any current physical problems, complaints, and/or concerns : _____

_____

Please list previous accidents and/or surgeries with dates (*broken bones, severe sprains, strains, whiplash, traumas, etc.*): _____

_____

Do you have any of the following? (*Please check YES or NO*)

High blood pressure?	☐ *Yes* ☐ *No*	Heart disease?	☐ *Yes* ☐ *No*	Cancer?	☐ *Yes* ☐ *No*
Circulation problems?	☐ *Yes* ☐ *No*	Kidney disease?	☐ *Yes* ☐ *No*	Diabetes?	☐ *Yes* ☐ *No*
Allergies?	☐ *Yes* ☐ *No*	Skin disorders?	☐ *Yes* ☐ *No*	Headaches?	☐ *Yes* ☐ *No*
Arthritis?	☐ *Yes* ☐ *No*	Low back pain?	☐ *Yes* ☐ *No*	Mid back pain?	☐ *Yes* ☐ *No*
Neck pain?	☐ *Yes* ☐ *No*	Shoulder pain?	☐ *Yes* ☐ *No*	Varicose veins?	☐ *Yes* ☐ *No*
Osteoporosis?	☐ *Yes* ☐ *No*	Swelling/Edema?	☐ *Yes* ☐ *No*	Seizures?	☐ *Yes* ☐ *No*
Pregnant?	☐ *Yes* ☐ *No*	Contagious disease (HIV/AIDS/Hepatitis/Infectious Disease)?		☐ *Yes* ☐ *No*	

Other medical conditions? ☐ *Yes* ☐ *No* If *Yes*, please describe: _____

Is there anything else I should know in order to make your experience a positive one? _____

_____

Consent for Services

I understand massage is provided for the purpose of relaxation and relief of muscular tension. I understand this is strictly a therapeutic massage treatment and any sexually suggestive remarks or behavior will result in immediate termination of treatment with full payment required. I am responsible for keeping my therapist informed of any changes in my physical condition which may affect my treatment. I also understand massage therapy is not a substitute for medical treatment or medications, and that it is recommended I concurrently work with my Primary Caregiver for any condition(s) I may have. I am aware my massage therapist does not diagnose illness or disease, nor prescribe medications and nothing said or done during the session should be construed as such. I agree my therapist shall not be personally liable for any damage or injury that may be sustained by me, either my person or my property, while on any premises where he is practicing. I have read the preceding information and understand my right/responsibilities as a client.

_____ _____

Client's Signature Date Trina Pinkney, LMT, RMT Date

Your appointment time has been reserved especially for you. I respectfully ask the courtesy of 24 hours notice to cancel or change appointment. Thank you.