

Massage Elements LLC
Karissa Spears CMT

Please fill out the following questionnaire to the best of your ability so that I may provide you the best professional care and service. All information will be kept confidential.

Name _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Occupation _____ Fax # _____ Email Address _____
 Sex: Male/Female DOB ____/____/____ Age _____ Referred to our office By _____
 Are you pregnant? _____ Due Date _____ Are you considered high Risk? _____ If so explain _____

Have you received massage therapy before? _____ Frequency _____
 Reason for today's visit: _____

_____ Any part of your body you wish not to be worked on? _____

Is your condition due to an accident or illness? _____ What/When? _____

Any surgical operations within the last 5 years? _____ What/When? _____

Doctor's Name _____ Phone Number _____

Current medications/supplements/herbs taken _____

Please list any exercise/stretching activities you currently do _____
 _____ Frequency _____

Allergies/Sensitivities _____

Emergency Contact: _____ Phone # _____ Relationship _____

Would you like to receive (coupons, announcements, promotions) **circle one: By Mail, Email or No Notification

Please check if you have had recent problems with any of the following:

____ Skin Condition/Rash

Where _____

____ Contagious conditions

Where _____

____ Areas of Inflammation

Where _____

____ Blood Pressure: High/Low

____ Osteoporosis

____ Seizures/Convulsions

____ Dizziness/Fainting

____ Bruise easily

____ Bursitis _____ Arthritis

Where _____

____ Shortness of breath

NECK:

____ Stiffness

____ Grinding/Popping

____ Limited Movement

____ Pain after waking in am

____ Pain in PM

HEAD:

____ Headaches

Where _____

____ Shooting Pain

____ Loss of memory

____ Light bothers eyes

____ Ringing in ears

JAW:

____ TMJ

____ Grind teeth

SHOULDERS:

____ Can't raise arm

____ Pain with movement

____ Shooting pain

ARMS & HANDS:

____ Hands cold

____ Loss of grip strength

____ Shooting pains

____ Numbness/Tingling

HIPS, LEGS&FEET:

____ Phlebitis

____ Swollen ankles

____ Ticklish feet

____ Shooting pains

____ Sciatica

____ Aching/grinding/popping

in joints

____ Varicose veins

____ Spider veins

LOWER BACK:

____ Stiffness

____ Pain

Pain is worse when:

____ Lifting

____ Sitting

____ Lying down

____ Bending

____ Standing

____ Coughing

____ Waking in AM

____ Pain in PM

ABDOMEN:

____ Nausea

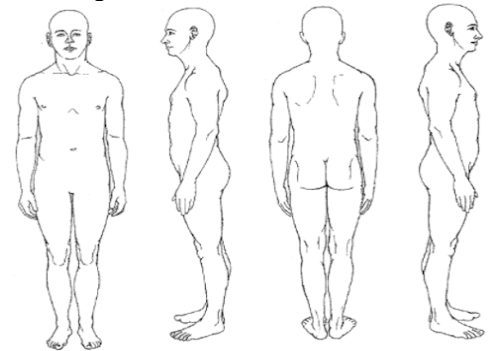
____ Gas

____ Constipation/diarrhea

____ Tenderness

Other _____

****Please CIRCLE areas of discomfort on the diagrams:**



Client Signature _____ **Date** _____

Client Policies

(Please read the following policies and sign at the bottom)

- Cancellation Policy: 24 hours notice is required when canceling your scheduled appointment. I understand that emergencies come up and exceptions will be honored. If there are repeated cancellations, full price will be charged for the missed appointments. Please remember that there are limited appointments available. To be fair to all of my clients, all cancellations must be made at least 24 hours prior to scheduled appointments.
- Late Policy: If you are late to your scheduled appointment, I will try to accommodate you as best as possible. Because I schedule most of my appointments back-to-back, I may not be able to give you the entire scheduled time. Depending on how late you are, you may either reschedule, or you may take the remainder of your scheduled time for full price. Please try to arrive 5 minutes early to your sessions so you may relax and not worry about being late!
- No Sexual Innuendos or Advances will be tolerated: Sexual contact of any kind will result in the immediate termination of the session and you will be liable for payment (in full) for the appointment.
- I must be notified PRIOR to the session if you have any of the following: open wounds, lesions, cuts, bruises, stitches, contagious diseases or illnesses. All information will be kept in strict confidence. This information is solely for my safety and your comfort.
- All information on the health history form and any information disclosed during your session will be kept confidential. I will do my best to honor your privacy, your space, your health. You are in charge of your health; I am here to help you heal yourself. So don't be afraid; ask questions, tell me what you like or dislike, and participate!

I have read and understand the above stated policies and procedures. By signing below, I am agreeing to comply with all statements noted above. I understand that I am receiving a therapeutic massage for the purpose of relaxation and/or the relief of muscular pain. Massage services are designed to be a health aid and are in no way to take place of a doctor's care. I understand that the Massage Therapist can't and won't diagnose nor prescribe any medications. I also understand that the massage may or may not alleviate current conditions. I understand that any sexually suggestive remarks or advances made will result in immediate termination of the session and that I will be liable for the payment (in full) for the appointment.

Signature _____

Date _____