

Lissa Becker – Licensed Massage Therapist
Neuromuscular Therapy and Pregnancy & Postpartum Massage

Client Information

Name _____

Address _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Cell) _____

Occupation _____ Employer _____

Birthday _____ Referred by (friend, yellow pages, internet, etc) _____

Have you had a professional massage before? Yes No

Primary reason for seeking massage today _____

Areas of complaint, pain, or tension _____

How would you describe your general health? Poor Fair Good Excellent

Please indicate the level of stress in your life: Low 1 2 3 4 5 6 7 8 9 10 High

How do you de-stress? _____

Do you drink water each day? Yes No If yes, a little moderate a lot

Do you drink caffeinated beverages? Yes No If yes, how many per day? _____

Do you use a computer? Yes No If yes, how many hours per day? _____

Do you exercise? If yes, what type of activity do you do and how often? _____

Are you pregnant? Yes No

Please indicate if you have any of the following conditions:

- | | | |
|--|---|--|
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Joint Disease/Stiffness/Swelling | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Bone Fractures | <input type="checkbox"/> Athlete's Foot |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis (Location) | <input type="checkbox"/> Plantar's Warts |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Muscular Injuries | <input type="checkbox"/> Taking Blood Thinners |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Spinal Problems | |
| <input type="checkbox"/> Numbness/Tingling/Twitching | <input type="checkbox"/> Headaches | |
| <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Diabetes | |

Do you have or have you had any other medical condition, symptom, or problem with regard to your health, fitness, or any structural condition that I should be aware of prior to administering massage therapy? If yes, please describe: _____

I understand and agree to the following:

- 1) Massage therapy is for the purpose of stress management, relief of muscular tension, general relaxation, and improvement of circulation and energy flow.
- 2) The massage therapist does not diagnose illness or disease, or prescribe pharmaceuticals; nor does she perform spinal manipulations.
- 3) Massage therapy is a complement to and not a substitute for professional medical care. I have stated all of my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.
- 4) All massage are non-sexual. I understand that if I should act inappropriately during a treatment or have sexual intentions relating to the treatment, the treatment will be terminated immediately and I will be liable for full payment of the treatment. And I will not be allowed back for future treatments.
- 5) All treatments start and end within the scheduled time slot.

With these conditions in mind, I agree that the massage therapist cannot be held liable for any problems I believe arise as a result of my massage treatments.

Signature _____

Date _____

**If you are unable to make your appointment,
please provide 24 hours notice of cancellation.
Failure to give 24 hours notice will result in
a charge of 50% of your scheduled appointment fee.**

**If you have a cold,
please call to reschedule your appointment.**

**Receiving a massage when you have a cold
may aggravate your condition
and make you feel worse.**

**Plus, you want to be sure that
you don't contaminate others.**

Thank you.