Lifelight Massage

Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Address: _____

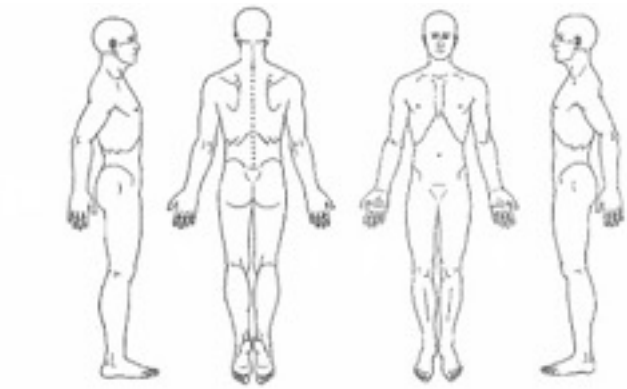
City/State/Zip: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

The following information will be used to help plan safe and effective massage sessions. Please answer the following questions to the best of your knowledge.

1. Who referred you to Lifelight Massage? _____
2. Have you had a professional massage before? Yes No
   If yes, how often do you receive massage therapy? _____
3. Do you receive chiropractic care? Yes No
   If yes, how often? _____
4. Do you have any allergies to oils, lotions, or ointments? Yes No
   If yes, please be specific. _____
5. Are you currently taking any medication? Yes No
   If yes, please identify. _____
6. Is there any particular area of the body where you are experiencing tension, stiffness, pain, or other discomfort? Yes No
   If yes, please identify. _____
7. When did this pain/discomfort first appear? _____
8. Do you know what caused this pain/discomfort? Yes No
   If yes, please explain. _____
9. Do you have any specific goals in mind for this massage session? Yes No
   If yes, please explain. _____

10. Circle any specific areas you would like the therapist to concentrate on during the session:



11. Have you had any surgeries? Yes No
    If yes, please explain. _____

_____

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12. Please check any condition listed below that applies to you.

contagious skin condition	phlebitis
open sores or wounds	deep vein thrombosis/blood clots
easy bruising	joint disorder/arthritis/tendonitis
recent accident or injury	osteoporosis
recent fracture	epilepsy
recent surgery	headaches/migraines
artificial joint	cancer
sprains/strains	diabetes
current fever	decreased sensation
swollen glands	back/neck problems
allergies/sensitivity	fibromyalgia
heart condition	T.M.J.
high or low blood pressure	carpal tunnel syndrome
circulatory disorder	tennis elbow
varicose veins	pregnancy (If yes, how many months?) _____

13. Please explain any condition that you have marked above. _____

_____

_____

14. Is there anything else about your health history that you think would be useful for the therapist to know to plan a safe and effective massage session for you? _____

_____

_____

Vocal Health

(Please complete this section if you will be receiving vocal massage)

1. Who is your E.N.T/Otolaryngologist? _____
2. Who is your speech pathologist/voice teacher? _____
3. How would you describe your vocal health? Please describe any pain, discomfort, or difficulty when speaking or singing. _____

_____

4. Have you received a diagnosis from your E.N.T./Otolaryngologist? Yes No

   If yes, please specify. _____
5. Have you ever suffered from whiplash? Yes No

I, _____ , understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this 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 and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of Client: _____ Date: _____