AWARENESS *Massage and Wellness Center, LLC*
9853 Johnnycake Ridge Rd, Suite 306A 440-231-3824 www.awareness.massagetherapy.com

CLIENT HEALTH HISTORY

Name _____ **Male**_____ **Female** _____
Phone (home/cell) _____ DOB _____
Address _____ City _____ State/Zip _____
E-mail: _____ Occupation _____
YES ___, please send me email promotions and educational newsletters
How did you hear about us?/Referred by? _____
In case of emergency: _____ Phone _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage session? **No** ___ **Yes** ___ How Recently?_____
Do you have tension, soreness and/or restricted movement in a specific area? If yes, explain _____
_____
What are your massage goals?_____
What kind of pressure do you prefer? **light** ___ **medium** ___ **firm** ___ **don't know** ___
If you answer "yes" to any of the following questions, please explain as clearly as possible.
No___**Yes** ___ Do you frequently suffer from stress? If yes, what level? **HIGH** ___ **MEDIUM** ___ **LOW** ___
No___**Yes** ___ Do you experience headaches? _____
No___**Yes** ___ Are you pregnant? _____
No___**Yes** ___ Do you have varicose veins? _____
No___**Yes** ___ Do you have diabetes? _____
No___**Yes** ___ Do you suffer from arthritis? _____
No___**Yes** ___ Do you suffer from joint swelling? _____
No___**Yes** ___ Do you have osteoporosis? _____
No___**Yes** ___ Any broken bones in the past two years? _____
No___**Yes** ___ Do you bruise easily? _____
No___**Yes** ___ Do you have spinal problems? _____
No___**Yes** ___ Do you suffer from epilepsy or seizures? _____
No___**Yes** ___ Do you have high blood pressure? _____
No___**Yes** ___ Do you have cardiac or circulatory problems? _____
No___**Yes** ___ Do you have any contagious conditions or diseases? _____
No___**Yes** ___ Do you have any allergies? _____
No___**Yes** ___ Any accidents or injuries in the past two years? _____
No___**Yes** ___ Have you ever had surgery? _____

Please list current medications _____
_____

Other medical/general conditions that I should know about? **No** ___**YES**___ _____
_____
_____

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I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension and pain. 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, or other qualified medical specialist for any mental or physical ailment of which I am aware. 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. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

_____ _____
Signature of Client Date

_____ _____
Signature of Massage Therapist Date

Consent to Treatment of Minor:
By my signature below, I hereby authorize _____ to administer massage or bodywork therapy techniques to my child or dependent, as they deem necessary.

_____ _____
Signature of Parent or Guardian Date

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GUIDELINES

CANCELLATION POLICY
We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all clients, the following policies are honored:
■ **24 hour advanced notice is required** when canceling an appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give us 24 hours advanced notice you **may** be charged the **full amount** of your appointment, payable prior to your next scheduled appointment.
■ **NO-SHOWS** If you choose not to attend your appointment and choose not to notify your therapist you will be charged for the "missed" appointment.
■ **LATE ARRIVALS** If you arrive late, your session may be shortened to accommodate the appointment following yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you **may** be responsible for the "full" payment of the session. Out of respect and consideration to your therapist and other customers, **please** plan accordingly and be on time.

CONFIDENTIALITY
The therapist does not share information about the session with others, other than relevant data pertaining to NGS billing requirements or BWC billing requirements. If the client would like the therapist to send a note to a physician, the client must make the request in writing.

TREATMENT
■ The client determines which pieces of clothing to be removed. Only the area being worked on will be exposed.
■ The therapist discusses what is most helpful for the specific treatment; however, the client makes the final decision.
■ The client determines which areas not to treat (i.e., no foot work due to being ticklish); likewise the therapist determines which areas not to treat (i.e., genitals, breasts).
■ The client will remain covered at all times and only the area being worked on will be uncovered.
■ The client needs to communicate the pain level or discomfort to the therapist.
■ The therapist generally does not initiate conversation unless required for treatment purposes. The client may engage in conversation or take the lead if her/she so desires. This approach allows the client to fully relax and receive a more effective treatment
■ Treatment is provided in a specific designated space that is used solely for massage and where the client's privacy is assured. Video surveillance is set up in the reception area only. This added security is utilized when a treatment session is in progress.
■ Absolutely no sexually suggestive remarks or advances are tolerated. Failure to comply will result in immediate termination of the session, and the client will be liable for payment of the scheduled appointment.

PAYMENT
■ Payment is due at the time service is rendered. Our services are GUARANTEED! If you are not satisfied with your level of service, payment will be waived or refunded.
■ Gift Certificates are available and are paid in advance of service; certificates are to be used within one year of purchase unless otherwise indicated.

The following are normal responses to relaxation and/or touch, which sometimes occur during massage. You need not be embarrassed nor suppress them: movement or release of intestinal gas - crying - laughing - strong emotions - sighing - groaning - yawning - softening of muscle tissue - cognitive or felt memories - stomach gurgling - the need to move or change position.

AGREEMENT

We agree to adhere to the specified boundaries listed above. If for some reason the client cannot adhere to the boundaries, the therapist will discuss a course of action that may result in a right to refuse treatment of the client.

Client's signature _____Date_____

Massage therapist's signature _____Date_____