

CLIENT HISTORY INFORMATION

Zardus Art of Massage
1 Lincoln Ave, Gardiner ME 04345

info@zardusartofmassage.com / 207-446-7470

Name: _____ Date of Birth: _____

Mailing Address: _____

Phone Numbers: _____

Email Address: _____ OK to use email? yes no

Occupation: _____

Physicians Name and Phone _____ Approval to contact: yes no

Emergency Contact Name and Phone: _____

Referred by: _____

Have you had professional massage before? yes no Date of last massage: _____

List stress reduction activities, and frequency: _____

Describe any major diagnoses / conditions and chronic / ongoing pain location & pain level:

List any allergies/sensitivities to scents, oils, herbs, nuts or touch. If you are vegan and prefer a vegan lotion please note:

Check all that apply to your current health:

| | |
|--|---|
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Athlete's foot |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Circulatory Condition | <input type="checkbox"/> Fibromyalgia or Chronic Fatigue Syndrome |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> High/low blood pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Spinal injury/surgery |
| <input type="checkbox"/> Infection | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Breathing difficulty | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Tendonitis | <input type="checkbox"/> HIV/AIDS |

Is there anything else your massage therapist should know? Please explain.

It is my choice to receive massage therapy. I agree to communicate with my practitioner any time I feel as if my well-being is being compromised. I understand that potential risks of massage include: mild, short term muscle soreness due to movement of irritating metabolic wastes; mild surface level bruising.

I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal or skeletal manipulations.

I understand that any illicit or sexually suggestive remarks or advances made by me, the client will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health.

Client Signature: _____ Date: _____

CONSENT TO TREATMENT OF MINOR: I hereby authorize the above-named I to administer massage/bodywork to my child or dependent as they deem necessary.

Signature of Parent or Guardian: _____ Date: _____