your ultimate massage
MM23007

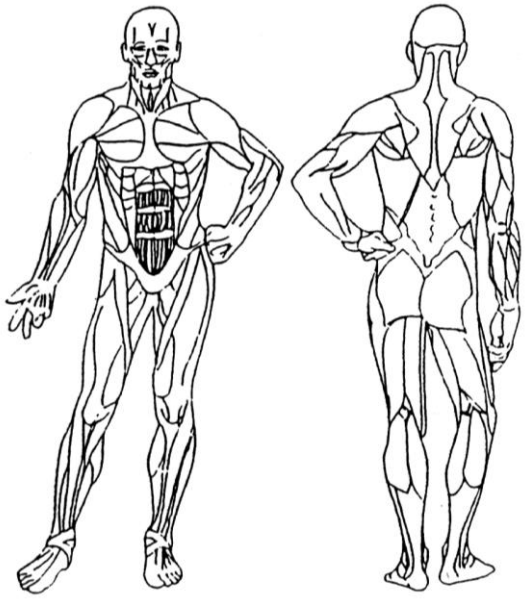
Client_____ Email _____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Occupation_____ Date of Birth_____

Please use the figure below to mark any areas that should be **avoided** during your massage.



## General History

Primary Health Care Provider _____

Check any of the following that presently apply to you:

| | | | |
|---|---|---|---|
| ___disease (any) | ___headache | ___bone/joint disorders | ___cancer |
| ___blood clots | ___pregnancy | ___varicose veins | ___injury |
| ___bruises | ___constipation | ___recent surgery | ___fever |
| ___rash | ___cardiac problems | ___ inflammation/swelling | ___ diabetes |
| ___arthritis | ___hernia | ___open cuts/sores | ___vertigo |
| ___fibromyalgia | ___HIV | ___epilepsy/seizures | ___hepatitis |
| ___high blood pressure | | ___allergies (lotions, scents) | ___herpes |

___other _____

(OVER)

Current Medications | Reason for the Medication

Surgery | Date

**----------informed consent----------**

I have been informed about the proposed treatment, including the sequence, possible techniques, areas of emphasis, duration of treatment, and associated fees. Furthermore, I certify that I have provided the therapist with any and all medical information that may have bearing on the effects of this treatment. I agree with the professional guidelines outlined during this intake session, and understand that both I and/or the therapist have the right to terminate the treatment at any time and for any reason. It is my responsibility to communicate any discomfort throughout the treatment. I hereby certify that I am requesting the proposed treatment. I also give my permission for Barbara Riché to discuss my massage therapy with my health care provider:

_____ _____/_____/_____

client signature | today's date

Thank you for making your ultimate massage part of your health care team!