



This form must be submitted 24 hours prior to your session to ensure there are no contraindications that may need further discussion or a doctor's clearance.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

***Before you receive bodywork, please answer the following questions:***

Are you pregnant? Yes / No If yes what is your EDD? \_\_\_\_\_

Have you had a surgery within the last 30 – 60 days? \_\_\_\_\_

Do you have Diabetes? Yes / No If yes, are there any complications? \_\_\_\_\_

Are you currently under a doctor's care for anything? \_\_\_\_\_

Do you have any old or new injuries? (i.e., car accident, etc.)  
\_\_\_\_\_

Do you have any type of heart conditions?  
\_\_\_\_\_

Are you currently taking any medications? If yes, what & what for?  
\_\_\_\_\_

Are there specific things you would like addressed in this session?

Sciatic Pain / Headaches / Low Back Pain / Upper Back Pain / Swelling

Other: \_\_\_\_\_

Do you prefer light, moderate, hard-deep pressure during your massage? (*circle one*)

Do you prefer silence (no talking) during your massage? YES / NO

Is it okay to get oil in your hair and on your face? (for cranial work) YES / NO

Do you have any allergies? (i.e., Eucalyptus or Menthol) YES / NO

Would you like to be placed on a mailing list to receive updated massage information, special offers, etc. via email? YES / NO

I understand that should my condition change in any way I am responsible for notifying my practitioner immediately and I am aware that I may need a doctor's clearance before my practitioner can work with me because of the change in my condition.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_