Gentle Touch Therapeutic Bodywork **11000 Spain Bldg. E, Abq. 87111**

(505) 293-3703 **Form # 1**

Client Name:_____ **Telephone:** _____**Date of Birth:**_____

Address: _____

Referred by: _____ **Telephone:** _____

In case of Emergency: _____**Telephone:** _____

Doctor: _____**Telephone:** _____

General & Medical Information

Age: _____ □ Male □ Female

Occupation: _____

□ Yes □ No Have you ever experienced a professional massage or bodywork session?

If you answer "yes" to any of the following questions, please explain as clearly as possible.

□ Yes □ No Do you frequently suffer from stress?	□ Yes □ No Do you have cancer or history of?
□ Yes □ No Do you have diabetes?	□ Yes □ No Have you been in an accident or suffered any injuries in the past two years?
□ Yes □ No Do you experience frequent headaches?	□ Yes □ No Do you have tension or soreness in a specific area?
□ Yes □ No Are you pregnant?	□ Yes □ No Do you have cardiac or circulatory problems?
□ Yes □ No Do you suffer from arthritis?	□ Yes □ No Do you suffer from back pain?
□ Yes □ No Are you wearing contact lenses?	□ Yes □ No Do you have numbness or stabbing pains anywhere?
□ Yes □ No Do you have high blood pressure?	□ Yes □ No Are you very sensitive to touch or pressure in any area?
□ Yes □ No Are you taking any medications?	□ Yes □ No Do you have any other medical condition I should be aware of?
□ Yes □ No Do you suffer from epilepsy or seizures?	
□ Yes □ No Do you suffer from joint swelling or edema?	Comments:
□ Yes □ No Do you have varicose veins?	
□ Yes □ No Have you ever had surgery?	
□ Yes □ No Do you have any contagious disease?	
□ Yes □ No Do you have osteoporosis?	
□ Yes □ No Do you bruise easily?	

Please take a moment to carefully read the following information and sign where indicated.

I understand the massage services are designed to be a health aid and are in no way to take the place of a doctor's care where it is indicated. Because massage/bodywork should not be performed under certain medical conditions, a referral from your primary care provider may be required prior to service being provided. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

Client Signature_____ Date:_____

Practitioner Signature _____ Date:_____

By my signature below I authorize administration of massage, bodywork, or somatic therapy techniques to my child or dependent as deemed necessary by the practitioner.
Signature of Parent or Guardian: _____ Date: _____