

Massage

Health History

Jupiter Massage and Pilates

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

ZipCode: _____ Cell: _____

Email: _____ Occupation: _____

Would you like to receive occasional promotional emails from us? *Please circle Y / N*

How did you hear about us?

Google _____ TripAdvisor _____ Referral (please provide their name) _____

Yelp _____ Facebook _____ Vehicle Wrap _____ Other _____

Have you ever experienced professional massage? _____

How frequently? _____ Pressure preferred? _____

Please describe your reason for the visit, including any current complaints or areas of discomfort: _____

Please circle any that may apply:

High Blood Pressure Heart Problems Muscle Cramps Shortness of Breath

Diabetes Joint Problems Pregnancy Vertigo

Fractures Chronic Illness Chronic Fatigue Seizures

Asthma Osteoporosis Scoliosis Acute Injury

Other: _____

Are there any areas you would like me to avoid? _____

Past surgeries/injuries and dates: _____

Please describe any physical activity you do and how frequently: _____

Please list any current medications: _____

In case of emergency, contact: Name _____ Number: _____

Please take a moment to read the following and sign below:

I understand that the massage/bodywork I receive is provided for the purpose of relaxation and relief of muscle tension. If I experience pain or discomfort during the session I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my comfort level. I further understand that massage/bodywork should not be construed as a substitute for medical treatment. I understand that massage/bodywork practitioners are not qualified to diagnose, prescribe or treat physical or mental illness and that nothing said in the course of the session given should be construed as such.

Because massage/bodywork should not be performed under certain conditions, 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. 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.

I understand that if I cancel an appointment within 24 hours of the scheduled appointment time, I am responsible for payment of half the session.

Client's Signature: _____ Date: _____

Practitioner's Signature: _____ Date: _____