Hideaway Massage
...where the locals go

Name_____Phone:_____DOB_____

Address_____City& State_____Zip_____

E-Mail_____

How did you hear about us?_____

Please review and answer the following questions carefully, as certain medical conditions or symptoms may be contraindicated by massage or bodywork. A referral from your health care provider may be required prior to service being provided. *Please check only those that apply:*

- ⌗ Do you frequently experience stress?
- ⌗ Do you have diabetes?
- ⌗ Do you have a thyroid condition?
- ⌗ Do you experience frequent headaches?
- ⌗ Are you pregnant?
- ⌗ Do you have cardiac or circulatory problems?
- ⌗ Do you have high blood pressure?
- ⌗ Do you have epilepsy or seizures?
- ⌗ Do you have joint swelling or arthritis?
- ⌗ Do you have varicose veins?
- ⌗ Do you have any contagious disease?
- ⌗ Do you have osteoporosis
- ⌗ Do you have any allergies or sensitivities?
- ⌗ Do you bruise easily?
- ⌗ Have you ever had broken bones or major injuries?
- ⌗ Do you have back pain or disk herniation?
- ⌗ Do you experience numbness or stabbing pains?
- ⌗ Are you sensitive to touch or pressure in any area?
- ⌗ Have you ever had surgery?

If you checked any of the above, please explain as well as list any existing medical conditions or medications you are taking:_____
_____

Have you ever had a professional massage, and if so how recently?_____

What are your goals for today's treatment?

⌗ Pain relief ⌗ Relaxation ⌗ A blend of both

What kind of pressure do you prefer?

⌗ Light ⌗ Medium ⌗ Firm

I understand that the massage treatment I receive is provided for the basic purpose of relaxation and relief of muscle tension, and is not to be construed as a substitution for medical diagnosis or treatment. Because massage should not be performed under certain medical conditions, I affirm I have stated all my known medical conditions and history and answered all questions honestly. I agree to keep the practitioner updated to any changes in my medical profile. 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 full payment of the appointment.

Client Signature_____Date_____

Practitioner Signature_____Date_____

Consent to treatment of a minor: By my signature below, I hereby authorize_____
to administer bodywork/massage to my child as they deem necessary.
Signature of Parent/Guardian_____Date_____