Blissful Beginnings & Beyond
Client Information Form for Clients with NO History of Cancer Treatment

Name:_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone# (Home)_____ **(Cell)**_____ **Email** _____

Preferred Method of Contact: ____Home Phone ____ Email ____Cellphone Do you want to receive text messages for appointment reminders and discount specials? ___ No ___Yes (if yes, provide cellphone carrier co)_____
Occupation_____ **Employer**_____

Emergency Contact _____ **Phone #** _____ **Relationship** _____

Medications_____ **Physician**_____

Age_____ **Birth Date**_____ **Referred By**_____

Primary reason for appointment:_____

Areas of complaint, pain or tension:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING THE APPROPRIATE ANSWER:

YES NO Have you had a professional massage before?
YES NO Have you ever had surgery?
If YES, please describe_____
YES NO Do you wear contact lenses or dentures?
YES NO Do you have any skin problems or allergies?
YES NO Do you take any prescribed medication?
If YES, please describe_____
YES NO Have you had any broken bones or acute injury in the past 2 years?
If YES, please describe_____
YES NO Do you have arthritis or osteoporosis?
YES NO Are you epileptic or seizures?
YES NO Are you diabetic?
YES NO Do you have varicose veins, phlebitis or blood clots?
YES NO Do you have cardiac or circulatory problems?
YES NO Do you exercise regularly or participate in any sports?
If YES, what kind and how often_____
YES NO Do you have any spinal problems?
If YES, what is diagnosis_____
YES NO Are you pregnant?
YES NO Do you have high blood pressure?
YES NO Do you have tension or soreness in a specific area?
If Yes, please describe_____
YES NO Do you have any other medical condition I should be aware of?
If Yes, please describe_____

Please take a moment to carefully read the following information and sign where indicated.
If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service. I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. 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. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a qualified medical specialist for any mental or physical ailment that I am aware of. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and 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 fail 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.
Client Signature_____ Date_____
Practitioner Signature_____ Date_____
Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage, bodywork or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian:____ Date:____________________________