CONFIDENTIAL INFORMATION

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: Name/#/Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check any of the following that apply to you—in the past mark (P) or currently mark (X):**

\_\_\_ Heart Problems \_\_\_ Arthritis \_\_\_ Spinal Problems

\_\_\_ High Blood Pressure \_\_\_ Osteoarthritis \_\_\_ Disc Problems

\_\_\_ Heart Attack \_\_\_ Stroke \_\_\_ Knee/Shoulder Injuries

\_\_\_ Blood Clots \_\_\_ Back Problems \_\_\_ Accidents or Injuries

\_\_\_ Varicose Veins \_\_\_ Pregnant \_\_\_ Major Illiness/Disease

\_\_\_ Pacemaker \_\_\_ Diabetes \_\_\_ Breaks/Sprains

\_\_\_ Neurological Problems \_\_\_ Surgery \_\_\_ Cancer

\_\_\_ Headaches \_\_\_ Epilepsy or Seizures \_\_\_ Skin Conditions

\_\_\_ Allergies \_\_\_ Bruise Easily \_\_\_ Sleeping Conditions

\_\_\_ Whiplash \_\_\_ Chemical Dependency \_\_\_ Constipation/Diarrhea

\_\_\_ Auto-Immune Disorders \_\_\_ Depression, Panic Disorder

(AIDS, Fibromyalgia, Chronic or Other Physiological Issues

Fatigue, Lupus, etc.)

Please list any medications (prescription or O.T.C.), vitamins and supplements you are currently taking:

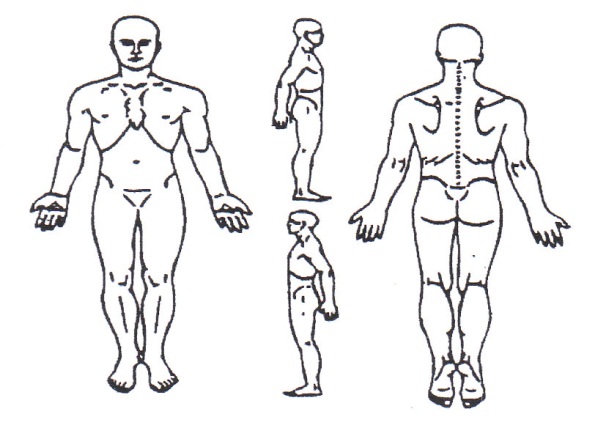
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under the care of a physician, chiropractor or alternative medicine practitioner? If yes, what are you being treated for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle any areas you may be experiencing pain or discomfort.



Please describe any pain or discomfort you may be experiencing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release Form**

I understand that the purpose of massage therapy is for relaxation and to reduce muscular tensions and that it is not meant to diagnose or treat any illness, disease or any other physical or mental disorder, injury or condition. I have informed my therapist about my health history and have answered the questions, to be as I know it, true and accurate. I know that any recommendations from the therapist are just suggestions and they are not a means of a prescription. I understand that if I cancel a session less than 24 hours in advance, I will be billed for that session.

The Client/Patient assumes full responsibility for their injuries. They or any member of their family fully releases Advanced Muscular Therapy, it’s owner or any of it’s therapists from any and all claims, demands, damages, rights of action, or cause of action, present or future and accept full responsibility for any injury that may occur by receiving treatment at this facility. Whether the same is known or unknown, anticipated, resulting from or arising out of the client/patient use or intended use of   
the facility and equipment thereof.

By the execution of this agreement, the Client/Patient assumes full responsibility for any such injuries or damages which may occur to the Client/Patient in or about the premises. The Client/Patient expressively agrees that Advanced Muscular Therapy, it’s owner, any of it’s therapists and the landlord of the property shall not be liable for any damages arising from personal injuries sustained by the Client/Patient in or about the premises. The Client/Patient does hereby fully and forever release and discharge Advanced Muscular Therapy, it’s owner or any of it’s therapist from any and all claims, demands, damages, rights of action or cause of action present or future.

The Client/Patient agrees that he/she has read and fully understands this release form.

**Client/Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Patient is responsible for payment not covered by insurance)