Weldon Spring Massage Therapy, LLC

5055 Hwy N, Ste. 213, Cottleville, MO, 63304
(636) 385-3965

Name: _____ **Phone:** _____

Address: _____

City/State/Zip: _____

Email: _____ **Date of Birth:** _____

Occupation: _____ **Emergency Contact:** _____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Date of Visit: _____

1. Have you had a professional massage before? **Yes** **No** Date of last session: _____
2. Do you have any difficulty lying on your front, back, or side? **Yes** **No**

   Please explain: _____
3. Do you have any allergies to oils, lotions, or ointments? **Yes** **No**

   Please explain: _____
4. Do you have sensitive skin? **Yes** **No**
5. Are you wearing **contact lenses** ( ), **hearing aids** ( ), or **dentures** ( )?
6. Do you sit for long hours at a workstation, computer, or driving? **Yes** **No**

   Please explain: _____
7. Do you perform any repetitive movements at work, sports, or hobby? **Yes** **No**

   Please explain: _____
8. Do you experience stress in work, family, or other aspect of your life? **Yes** **No**

   If so how do you think it has affected your health?

   ( ) **Muscle tension** ( ) **Anxiety** ( ) **Insomnia** ( ) **Irritability**

   ( ) **Other** _____
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain, or other discomfort? **Yes** **No**

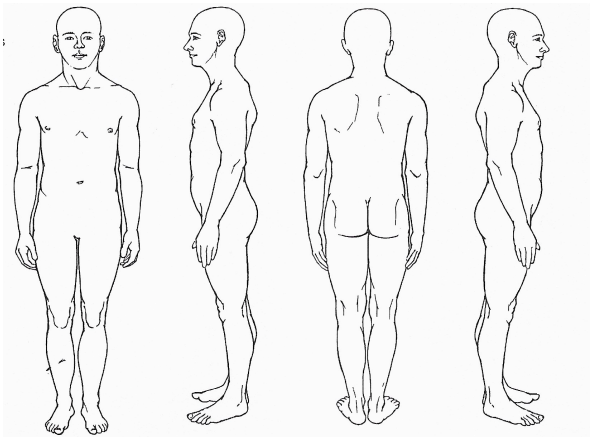
   Please explain: _____
10. Do you have any particular goals in mind for this massage session? **Yes** **No**

    Please explain: _____

Circle any specific areas you would like the massage therapist to address during the session.

Also label:

P = pain or tenderness
S = Joint or muscle stiffness
N = Numbness or tingling



In order to plan a massage session that is safe and effective, I need some general information about your medical history.

1. Are you currently under medical supervision? **Yes** **No**

   Please explain: _____

2. Do you see a chiropractor? **Yes** **No** **How often?** _____

3. Are you currently taking any medications? **Yes** **No**

   Please list them: _____

   _____

4. Please check any conditions that apply to you:

   ( ) **Contagious skin condition**
   ( ) Open sores or wounds
   ( ) Easy bruising
   ( ) Recent accident or injury
   ( ) Recent surgery
   ( ) Artificial joint
   ( ) Sprains/strains
   ( ) Current fever
   ( ) Swollen glands
   ( ) Allergies/sensitivity
   ( ) Heart condition
   ( ) High or low blood pressure
   ( ) Circulatory disorder
   ( ) Varicose veins
   ( ) Atherosclerosis
   ( ) Phlebitis
   ( ) Deep vein thrombosis/blood clots
   ( ) Joint disorder/rheumatoid arthritis/ osteoarthritis/tendonitis
   ( ) Osteoporosis
   ( ) Cancer
   ( ) Epilepsy
   ( ) Headaches/ migraines
   ( ) Diabetes
   ( ) Decreased sensation
   ( ) Back/neck problems
   ( ) Fibromyalgia
   ( ) TMJ
   ( ) Carpal tunnel syndrome
   ( ) Tennis elbow
   ( ) Currently pregnant, # of months? _____

   Please explain anything you've marked above:

   _____

   _____

   _____

5. Is there anything else you can think of about your health history that can be useful for your massage therapist to know in order to plan a safe and effective massage session?

   _____

   _____

Draping will be used during the session; only the area being worked on will be uncovered. Clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session; informed written consent must be provided by a parent or legal guardian for any client under age of 18.

I, _____ , understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscle tension. If I experience any pain or discomfort during this and future sessions, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for a medical examination, a diagnosis, or a prescription to treat any mental or physical ailment, and that I should see a physician, chiropractor, or other qualified medical specialist. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, or prescribe to treat any mental or physical illness, and nothing said in the session should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapists part should I fail to do so.

Signature of Client: _____ **Date:**_____

Signature of Massage Therapist: _____ **Date**:_____