200 Washington Street Suite 105 Santa Cruz, CA 95060 831-818-0230	**Every *body* needs balance…** **Santa Cruz Balance Massage**	

CLIENT HISTORY

Today's Date: _____

Name:_____ Phone:(_____) _____

Email: _____ Date of Birth: _____/_____/_____

How did you hear about Santa Cruz Balance Massage? / Referred by:

☐ Groupon ☐ Yelp ☐ Google Search ☐ Yahoo Search ☐ Friend (Name) _____

☐ Other _____

Occupation / Repetitive Movements (helps to assess where to concentrate bodywork)

_____

Have you ever experienced a professional massage or bodywork session? Yes ☐ No ☐ How recently?_____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medication condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided:

Yes ☐ No ☐ Do you have any allergies or sensitivities (i.e. nuts, flowers, scents)?
Yes ☐ No ☐ Do you have diabetes?
Yes ☐ No ☐ Do you have neuropathy?
Yes ☐ No ☐ Do you have a thyroid condition?
Yes ☐ No ☐ Do you experience frequent headaches or dizziness?
Yes ☐ No ☐ Are you pregnant? If yes, how many weeks? ___ Previous miscarriages? ___
Yes ☐ No ☐ Do you suffer from arthritis?
Yes ☐ No ☐ Are you wearing contact lenses or dentures?
Yes ☐ No ☐ Do you have cardiac or circulatory problems?
Yes ☐ No ☐ Do you have peripheral vascular disorder?
Yes ☐ No ☐ Do you have high blood pressure?
Yes ☐ No ☐ Do you suffer from epilepsy or seizures?
Yes ☐ No ☐ Do you suffer from joint swelling?
Yes ☐ No ☐ Do you have varicose veins?
Yes ☐ No ☐ Blood clots/prone to blood clots?
Yes ☐ No ☐ Depressed immune system? (Lupus, HIV /AIDS, Epstein Barr, mononucleosis, etc.)
Yes ☐ No ☐ Do you have any skin conditions?
Yes ☐ No ☐ Do you have any nerve trauma?
Yes ☐ No ☐ Do you have any contagious diseases?
Yes ☐ No ☐ Do you have osteoporosis?
Yes ☐ No ☐ Do you bruise easily?
Yes ☐ No ☐ Any broken bones in the past two years
Yes ☐ No ☐ Any injuries in the past two years?
Yes ☐ No ☐ Any surgery in the past five years?
Yes ☐ No ☐ Do you suffer from back pain or disk herniation?
Yes ☐ No ☐ Do you have numbness or stabbing pains?
Yes ☐ No ☐ Do you have Gout?
Yes ☐ No ☐ Do you have Bursitis?
Yes ☐ No ☐ Do you have Cancer?
Yes ☐ No ☐ Are you sensitive to touch or pressure in any area?
Yes ☐ No ☐ Do you have heat sensitivity or taking any medications that have side effects to heat?
Yes ☐ No ☐ Other medical condition, or are you taking any medications (list below)?

Comments:_____

_____

_____

*****PLEASE TURN OVER TO COMPLETE OTHER SIDE *****

200 Washington Street
Suite 105
Santa Cruz, CA 95060
831-818-0230

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Santa Cruz Balance Massage

POLICIES

Please read ALL of the below and sign at bottom

The Basics:

- Cell phones off!
- Control of pressure is up to you. You can ask for less or more pressure.
- Any client under 18 is required to have a parent/guardian signed consent (below.)

Business Policies:

- I agree to a 24-hour cancellation policy or I will be charged for the full session.
- Massage sessions will end at the scheduled time, even if I am late in arriving. The session may be cancelled if I arrive more than 10 minutes late and I am responsible for paying the full price, even if I arrive late.
- I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the treatment, pressure and/or strokes may be adjusted to my level of comfort.
- I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.
- Because massage/bodywork/hot stone 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 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 responsible for full payment of the scheduled appointment.

I accept all the above policies: _____ Date: _____
Client Full Signature

Consent to Treatment of Minor: By my signature below, I hereby authorize Santa Cruz Balance Massage to administer massage to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date: _____