

*Skin Care Institute Massage Release*

Date \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_  
First Name Last Name Relation Phone

We like to notify clients of scheduled appointments, specials, and discounts. Would you allow us to have your Email Address? \_\_\_\_\_

Would you please help us by telling us how you heard about our spa?

\_\_\_ Television \_\_\_ Newspaper \_\_\_ Magazine \_\_\_ Radio \_\_\_ Website  
\_\_\_ Billboard \_\_\_ Your Physician \_\_\_ Yellow Pages/Phonebook \_\_\_ Other

Is there a friend or neighbor we may thank? \_\_\_\_\_

**Please list for any of the following:**

Are you currently seeing a Chiropractor? Yes \_\_\_ No \_\_\_

Have you ever received a professional massage? Yes \_\_\_, Date of last Massage \_\_\_\_\_ No \_\_\_

What type of pressure do you like? Soft \_\_\_ Firm \_\_\_ Deep \_\_\_ Therapeutic \_\_\_ Relaxing \_\_\_

Recent surgeries or injuries in the last year \_\_\_\_\_

Medications \_\_\_\_\_

Any Allergies that you may have: \_\_\_\_\_

Currently under a Physician's care? Yes \_\_\_ No \_\_\_

Pregnant? Yes \_\_\_ No \_\_\_ Due Date: \_\_\_\_\_

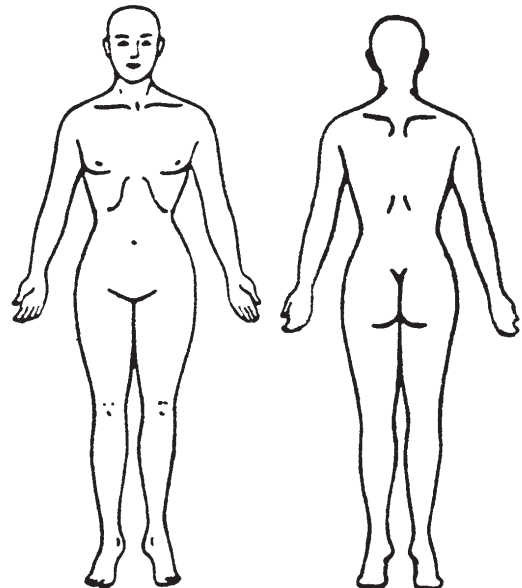
*Note\* Prenatal massage can and will only be given after the 1<sup>st</sup> Trimester due to contraindications to mother and baby.*

**Please check if you have at present or have**

**had a history of the following:**

- Dizziness     Sciatica     Headaches
- Arthritis     Numbness     Tension
- Diabetes     Heart Condition     Allergies
- Cancer     Nerve Condition     Bursitis
- Sinus     Low Blood Pressure
- Chronic Pain     High Blood Pressure
- Osteoporosis     Other

Please mark with (x) any areas of pain or concern:



**Lifestyle Background**

Type of work you do \_\_\_\_\_ Stress level:

High Med Low

Quality of sleep: Good Fair Poor Do you smoke? Yes No

How many glasses of water do you drink a day? \_\_\_\_\_

Do you exercise or participate in sports? Yes No

Describe \_\_\_\_\_

**Please Read the Following**

**It is my choice to receive massage therapy. I realize that the treatment is being given for the well being of my body and mind. This includes stress reduction, relief from muscular tension, spasms, pain, increasing circulation or energy flow. I agree to communicate with my practitioner at any time I feel like my well-being is being compromised.**

**I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is no substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.**

**I have stated all medical conditions that I am aware of and will continue to update the massage practitioner of any changes in my health status.**

**If under 18, we must have a legal guardians signature on file due to Oklahoma law.**

**Signed \_\_\_\_\_ Date \_\_\_\_\_**

**Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_**

**Relation to Patient \_\_\_\_\_**