

Massage 4 Life by Kimberly Alvarado

Name: _____ Date: _____

Email: _____ Phone: _____

Emergency Contact Name and Phone number: _____

Please indicate any condition that you currently have or have had in the past.

- | | | |
|---|--|--|
| <input type="checkbox"/> Spinal Problems | <input type="checkbox"/> Allergies | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> Kidney Issues | <input type="checkbox"/> Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Recent Infection | <input type="checkbox"/> Recent Injury | <input type="checkbox"/> Past surgeries |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other _____ |

***Please use the back of this page to explain any of the items that you checked above.**

Are you currently pregnant? _____ Due date? _____ Complications? _____

****I cannot massage anyone under 12 weeks pregnant.***

Current medications: _____

Use the back of this page if needed to list all medications.

Please list areas of pain/tension/limited range of motion: _____

Please list any areas to be avoided: _____

Types of massage you have received in the past: _____

Please tell me your massage goals: _____

When was the last time you received a massage? _____

What type of massage are you seeking? (You may check more than one.)

- | | |
|--|--|
| <input type="checkbox"/> Custom Massage** | <input type="checkbox"/> Cold Stone Facial |
| <input type="checkbox"/> Relaxation Massage* | <input type="checkbox"/> Manual Lymphatic Drainage |

**** Relaxation Massage is a light to medium-light Basic Swedish Massage***

*****Custom massage is a mix of Swedish, Myofascial Release, Trigger Point, Acupressure Points, Passive & Active Stretch and Release, Manual Lymphatic Drainage, & any enhancements you choose.***

I understand that massage therapy is not a substitute for medical examination or diagnosis. It is recommended that I see a physician for any physical ailment that I may have. I understand that the massage therapist does not prescribe medical treatments or pharmaceuticals and does not perform any spinal adjustments. I understand that any home exercises or stretches demonstrated are suggestions only and should be cleared by a doctor if I have any medical concerns, or if my condition worsens. I am aware that if I have any serious medical diagnosis, I must provide a physician's written consent prior to services.

I understand that the information I have provided on this form is true and correct, and I agree that I will inform the therapist if there are any changes to my health.

Per Texas State Law:

- **The licensee shall drape the breasts of all female clients and not engage in breast massage of female clients unless the client gives written consent before each session involving breast massage. (This is necessary for manual lymphatic drainage and some trigger point work. In either case, the work will be done on top of the linens.)**
- **Draping of the genital area and the gluteal cleavage will be used at all times during the session for all clients.**
- **The massage is non-sexual in nature. The licensee must immediately end the session if the client initiates any verbal or physical contact that is sexual in nature.**

The client is advised to inform the licensee if any modifications to temperature, pressure, draping, or techniques are needed at any time during the massage. Massage should never be painful.

If the client is uncomfortable for any reason, the client may ask the licensee to end the massage, and the licensee will end the session.

The licensee also has the right to end the session if uncomfortable for any reason. In the case of the session ending due to the client's inappropriate behavior, full payment will be expected.

Client signature: _____ Date: _____

(Parent or Guardian if under the age of 17.) _____

To be completed by the licensee:

Type of massage service/technique to be used:

Parts of body to be massaged (including indications and contraindications):

Licensee signature: _____ Date: _____

I agree to the following financial policies: If I arrive late, the minutes late will be deducted from my massage time. If I cancel or reschedule my appointment with less than 24-hours notice, I will be charged 50% of the cost of my appointment. If I do not show up for my appointment without calling in advance of my scheduled time, I will be charged the full price of my appointment. These charges will need to be paid before I can schedule another appointment. Massage for Life by Kimberly Alvarado has the right to collect these charges by using the card that I have on file, services I have prepaid, or by sending an invoice. Repeated cancellations and rescheduling will result in my having to prepay for further appointments.

Client signature: _____

Date: _____