Hilton
DFW LAKES
EXECUTIVE CONFERENCE CENTER

Massage Client Information

Name: _____ **Date:** _____ **Date of Birth:** _____

Address: _____

Phone: _____ **Email:** _____

Emergency Contact: _____ **Phone:** _____

By answering the following questions as completely and accurately as possible, you will assist your therapist in giving you the best massage possible.

Have you ever had a professional massage? _____ **If yes, how often?** _____

Is there anywhere you would NOT like to have massaged? _____

Is there anywhere you PREFER to have massaged? _____

Are you currently under the care of a physician for a particular ailment? _____

If yes, please provide the Doctor's name: _____

Are you currently taking any medications (including aspirin, ibuprofen or vitamins)? Please also list what the medication is being used to treat: _____

Please CIRCLE all that apply. Please be aware that some conditions do not permit your therapist to work with you as additional training and/or certification/license is required. Undue risk to your health and treatment may be involved.

Heart Disease	Diabetes	Tuberculosis	Colitis
Kidney Disease	Allergies to Oils	Prostheses	Phlebitis
High Blood Pressure	Allergies to Perfumes	TMJ syndrome	Osteoporosis
Low Blood Pressure	Epilepsy/Seizures	Warts	Lupus
Arthritis	Herniated/Fused Disk	Hepatitis	Flu/Cold
Gout	Neck Injury	Joint Replacements	Pregnant
Blood Clots	Spinal Injury	Joint Pins	Hyperthyroidism
Stroke	Whiplash	Cancer/Tumor	Hypothyroidism
HIV/AIDS	Varicose Veins	Chemotherapy	Nursing

Have you had any surgeries, accidents or serious illness in the last two years? _____

If you have a specific medical condition or specific symptoms, massage or bodywork may be contraindicated. A referral from your primary care physician may be required prior to service being provided. It is your responsibility to notify your therapist of any changes to your condition for your future visits. With your signature, you verify, that you understand that massage is therapeutic for the purpose of relaxation and muscle tension relief. If at any time, you experience pain or discomfort during the session, immediately inform your therapist so the massage can be adjusted for your comfort. The massage is not a substitute for medical treatment or diagnosis. It is your responsibility to see a physician, chiropractor or other qualified medical specialist for any physical or medical ailments that may occur.

_____ _____

Signature **Date** **Therapist** **Date**