INTEGRATED BODY ARTS

CRANIOSACRAL & MASSAGE THERAPY

Name:_____ Occupation: _____

Date of Birth: _____ your phone: _____

Email: _____

Emergency contact and phone: _____

What do you do to relieve stress? _____

Please take a moment to carefully read the following information. Although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis or treatment. If you have a specific medical condition or symptoms, massage/bodywork may be contraindicated. Please review this list and check those that apply.

Do you experience migraines or frequent headaches?	Y	N
Do you have diabetes?	Y	N
Are you pregnant? Weeks_____	Y	N
Do you have arthritis?	Y	N
Do you have high blood pressure?	Y	N
Do you have epilepsy or seizures?	Y	N
Do you have varicose veins?	Y	N
Do you have swelling of joints?	Y	N
Do you have any contagious diseases?	Y	N
Do you have osteoporosis?	Y	N
Do you have allergies?	Y	N
Have you had any surgeries?	Y	N
Any prior or recent injuries?	Y	N
Do you have any skin conditions?	Y	N
Do you have any circulatory conditions?	Y	N
Do you have numbness anywhere?	Y	N
Do you have neurological conditions?	Y	N
Are you sensitive to touch or pressure?	Y	N
Are you currently taking any medications?	Y	N
Do you have trouble sleeping/ insomnia?	Y	N
Do you have anxiety or depression?	Y	N
Have you ever had a head injury or concussion?	Y	N

If you answered YES to any of the previous questions, please explain as clearly as possible in the space provided below or feel free to discuss them with me. I am happy to discuss any other concerns or information you would like me to know.

_____

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Please read the following, sign and initial where indicated.

Consent for Care: It is my choice to receive manual therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health. _____**Initial**

Confidentiality: Client's records and sessions will be kept confidential and will not be shared with anyone without the client's written consent. _____**Initial**

Cancellation Policy: Cancellations require 24 hour notice to insure that we can re-book the appointment. A $30 cancellation fee will be assessed if appointments are cancelled less than 24 hours in advance. _____**Initial**

Signature:_____**Date**_____