Touch From The Heart
B. Mills, L.M.T.

CLIENT INFORMATION AND AGREEMENT FORM _____

PLEASE CHECK:	YES	NO
HAVE YOU HAD / DO YOU HAVE?		
Allergies to lotion	☐	☐
Allergies to oil	☐	☐
Allergies to fragrance	☐	☐
Arthritis	☐	☐
Blood clots	☐	☐
Bursitis	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Epilepsy	☐	☐
High blood pressure	☐	☐
Low blood pressure	☐	☐
Migraine headaches	☐	☐
Recent injury	☐	☐
Recent surgery	☐	☐
Spinal Injury	☐	☐
Skin problems	☐	☐
Tense muscles	☐	☐
Very ticklish spots	☐	☐
Varicose veins	☐	☐
DO YOU HAVE / ARE YOU CURRENTLY?		
Contacts in your eyes	☐	☐
An Infectious disease(s)	☐	☐
Heart trouble	☐	☐
Pregnant	☐	☐
Taking Medication	☐	☐

OTHER: _____

_____

_____

I know and understand the following:

1. The type of massage technique I anticipate using during the massage therapy session is Swedish Style, consisting of:
   - Effleuarage (gliding stroke)
   - Petissage (kneading)
   - Friction (rubbing)
   - Tapotement (percussion)
   - Vibration (shaking or trembling)
   - Range of Motion Movements and Stretching
2. The parts of the client's body that will be avoided completely are:
   - a) Genitals
   - b) Breast (even during lymphatic massage)
   - c) Any place a client does not want to be touched
   - d) If the client is uncomfortable for any reason, the client may ask to end session
3. Contraindications: a reason NOT to massage:
   - A) Serious Illness
   - B) Open skin, recently broken bone
   - C) Infectious disease, contagious illness
   - D) Fever
   - E) Blood clots
   - F) Extremes of blood pressure (uncontrolled)
   - G) Delicate or damaged tissue
   - H) Recent surgery
   - I) Cancer (unless written permission from Doctors on file first)
   - J) Client must be free of Alcohol and street drugs previous to massage
4. The modesty of each client and therapist is protected by proper client draping procedures.
5. The massage therapy given is for stress reduction, relief from muscular tension, and for enhancing the circulation.
6. I understand that this massage is not to be used in place of medical treatment.
7. It is recommended that I see a physician for any medical problems I might have.
8. I have submitted correct information regarding my state of health, medical history, injuries, and/or surgeries undergone.
9. I am free of communicable disease.
10. It is necessary for me to arrive 15 minutes before each appointment to have an interview with the therapist.
11. I am expected to make all appointments as scheduled. If I must cancel an appointment, I will do so 24 hours in advance. Your call is important to me and clients will be charged for no-shows.

_____ Client Signature

_____ Therapist Signature

_____ Date

_____ Referred by (Name, Advertising, etc.)

E-mail: _____

_____ Last Name _____ First name

_____ Street Address _____ Apt.

_____ City _____ State _____ Zip

(___) _____ Home Phone (___) _____ Work Phone

CLIENT HISTORY (Optional)

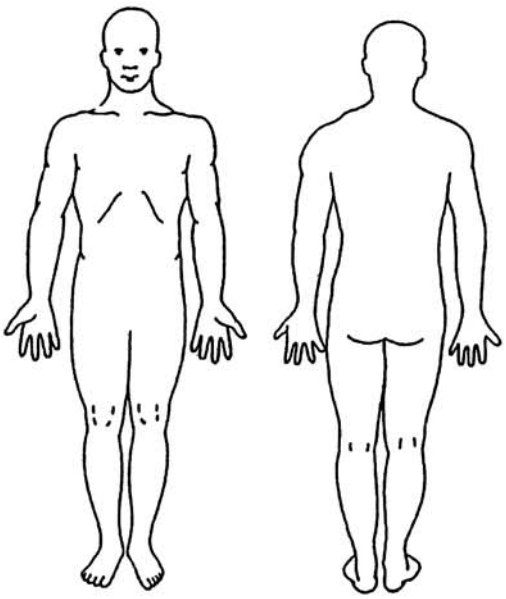
Birthday: _____

Hobbies: _____

_____

Type of Work: _____

_____



LEGEND

PPP	Area(s) where you are experiencing pain.
XXX	Area(s) that are tight.
TTT	Area(s) that are ticklish.

FOR THERAPIST USE ONLY

Date	Session Notes & Marketing Notations