# MEDICAL HISTORY QUESTIONNAIRE AND RELEASE OF LIABILITY

This is your medical history questionnaire and release of liability and must be completed prior to your first therapy. All information will be kept confidential and will be used for the evaluation of your health and readiness to begin our session. The form is extensive, but please try to make it as accurate and complete as possible. Please take your time and complete it carefully and thoroughly, and then review it to be certain you have not left anything out. Any questions will be thoroughly addressed afterwards.

**Personal Information:**

Name: ______________________________ Date of Birth: ____________________
Street Address: ______________ City: __________ State: ______ Zip Code: ____________
Phone Number: __________________ Email Address: ________________________
Occupation: ___________________ How did you hear about us? ____________________

**General Screening Questions:**

| | | |
|---|---|---|
| Have you ever had a professional massage session? | □ Yes | □ No |
| Do you have discomfort lying on your side, back or stomach? | □ Yes | □ No |
| Do you have reactions to oils, lotions or ointments? | □ Yes | □ No |
| Does your work require you to sit for long periods of time? | □ Yes | □ No |
| Do you have discomfort in your legs after walking short distances? | □ Yes | □ No |
| Are you experiencing tension, pain or discomfort? | □ Yes | □ No |
| Are you currently under the care of a physician or chiropractor? | □ Yes | □ No |
| Do you have any medical ailments or taking any medications? | □ Yes | □ No |

**Past Medical History - Please circle all those that apply**

| | | |
|---|---|---|
| Contagious skin conditions | Open sores and wounds | Easy bruising |
| Recent surgery | Artificial joints | Strains, sprains or fractures |
| Swollen or painful joints | Back or foot problems | Allergies or sensitivities |
| Heart condition to high blood pressure | Circulatory problems | Dizziness or fainting spells |
| Stroke | Varicose veins | Tennis elbow |
| Deep vein thrombosis (blood clot) | Headaches or migraines | Cancer |
| Phlebitis (inflammation of a vein) | TMJ | Carpal tunnel syndrome |
| Joint disorder, arthritis or tendonitis | Epilepsy or seizures | Fibromyalgia |
| Diabetes or abnormal blood-sugar tests | Pregnancy | Other________________ |

If yes to any of the above, explain:______________________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________

**I understand and agree to, that 24 hours cancellation notification is required or full cost of the session must be paid in full before another session can be booked.** I understand that the massage and bodywork that I am receiving is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure and manipulation may be adjusted to my level of comfort. I further understand that massage and bodywork should not be considered as a substitute for medical evaluation, injury determination/diagnosis or proper treatment by a medical professional. I understand that massage and/or bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnosis, prescribe or treat any physical or mental illness and that at no time do I consider my session to be construed as such. Because massage and/or body work should not be performed under certain medical conditions, I affirm that I have stated all of my known medical ailments and injuries. I agree to keep the practitioner updated to any changing conditions or medical concerns and that there is no liability on their part if I fail to do so. **I fully understand that any illicit or sexually suggestive remarks, suggestions or advances made by me will result in immediate termination of the session, that I will be financially responsible for full payment and that I will be prosecuted fully by the law.** By signing below, I accept full responsibility for my health at all times, including this session. I assume complete risk for such, holding harmless of any and all responsibility Amanda's Massage, their employees and/or independent contractors.

**Consent for treatment of Minor or Dependent:**

By signing below, I hereby authorize the stated practitioner to perform massage, body work and therapy procedures to my child or depended as they determine fit.

Client, Parent or Guardian Printed Name: ________________________________________
Client, Parent or Guardian Signature and Date: ___________________________________

Practitioner Printed Name: _______________________________________________
Client Signature and Date: _______________________________________________