

**Initial Massage Therapy Assessment**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City, St, Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Who may I thank for referring you? \_\_\_\_\_

Yes No Have you ever had a professional massage session? \_\_\_\_\_

Yes No Do you suffer from stress? \_\_\_\_\_

Yes No Do you experience frequent headaches? \_\_\_\_\_

Yes No Do you suffer from back pain? \_\_\_\_\_

Where? \_\_\_\_\_

Yes No Do you have numbness or stabbing pains?

Where? \_\_\_\_\_

Yes No Do you have tension or soreness? \_\_\_\_\_

Where? \_\_\_\_\_

Yes No Are you pregnant? \_\_\_\_\_

Yes No Are you diabetic? \_\_\_\_\_

Yes No Do you have high blood pressure? Please list medications \_\_\_\_\_

Yes No Have you ever had surgery? Please describe \_\_\_\_\_

Any other medical conditions I should be aware of?

Primary reason for treatment? \_\_\_\_\_

**Please take a moment to read the following paragraph and sign where indicated:**

If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated (should not be done). The massage therapy you receive is provided for the basic purpose of relaxation and relief of muscular tension. If you experience any pain or discomfort during a session, you must inform the therapists so that adjustments can be made. Massage is NOT a substitute for medical examination, diagnosis, or treatment. Massage therapists are NOT qualified to perform spinal or skeletal adjustments, diagnosis, or treat physical or mental illness. Because massage therapy is contraindicated under certain medical conditions, please state all known medical conditions and understand that the massage therapist can not be held liable if you forget to do so. \*\*\* Any illicit or sexually suggestive remarks or advances made by the client will result in immediate termination of the session, and the client will be liable for the payment of the scheduled appointment. The therapist will also adhere to the strict professional codes required by law as well as Davidson-Taylor Salon & Day Spa. Furthermore, I understand that I will be covered during the session and only the areas that are treated will be uncovered during treatment.

I have read and agree to the statements listed above:

Signature of Client: \_\_\_\_\_

Signature of Therapist: \_\_\_\_\_

(Please turn to the back of this sheet and mark the appropriate figure)