



AUTHENTIC EASTERN HEALTH LLC ACUPRESSURE CLIENT INFORMATION FORM

Name _____ DOB _____ Gender _____ Male/Female Date: _____

Address _____ City _____ Zip _____

E-Mail Address _____

Home Phone _____ Work _____ Cell _____

When is the best time to call? _____ Call which phone? _____ May we leave a message? _____

Emergency Contact _____ Contact Number _____

occupation _____ Referred by _____

MEDICAL INFORMATION

- Yes No Have you had a massage before? If yes, how recently? _____
- Yes No Do you frequently suffer from stress? _____
- Yes No Do you have diabetes? _____
- Yes No Do you experience frequent headaches? _____
- Yes No Are you pregnant? _____
- Yes No Do you suffer from arthritis? Where: _____
- Yes No Are you wearing dentures? _____
- Yes No Do you have high blood pressure? If yes, do you take medication? _____
- Yes No Do you suffer from epilepsy or seizures? _____
- Yes No Do you suffer from joint swelling? Where? _____
- Yes No Do you have varicose veins? _____
- Yes No Do you have any contagious diseases? _____
- Yes No Do you have osteoporosis? _____
- Yes No Do you have any allergies? _____
- Yes No Do you have any skin conditions? If yes, what are they? _____
- Yes No Do you bruise easily? _____
- Yes No Have you had any broken bones in the past two years? Please list: _____

- Yes No Have you been in an accident or suffered any injuries? If yes, what are they? _____

- Yes No Do you have cardiac or circulatory problems? _____
- Yes No Do you suffer from neck or back pain? _____
- Yes No Do you have numbness or stabbing pains anywhere? _____
- Yes No Are you very sensitive to touch or pressure in any area? _____
- Yes No Have you ever had surgery? Please explain: _____
- Yes No Do you have, or have you ever had cancer? _____
- Yes No Do you have any other medical condition or are you taking any medications I should know about? _____
- Yes No Do you have tension or soreness (including sprains/strains) in a specific area? Please specify. _____

- Yes No Do you exercise? Please list activities, frequency, and intensity: _____

- Yes No Do you have other concerns your massage therapist should be aware of? Please explain: _____

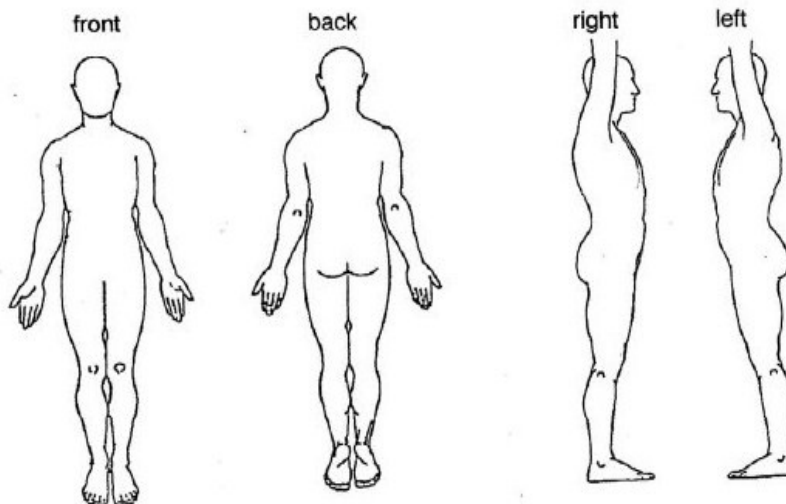
Over please

BODY MAP

Please complete the body map using the symbols below.

X – Areas I do NOT want massaged

O – Areas that need extra attention (pain, tension, or concern)



What are your goals of massage therapy?

RELEASE

Please read carefully and sign below.

I understand that the Acupressure Massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort. I also may request that the session be discontinued at any time, for any reason, and the therapist will honor that request.

I further understand that Acupressure Massage should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature: _____ Date _____

Therapist Signature: _____ Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage, bodywork or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____