



Name: _____ Date: _____

Phone: _____(C/W//H)_____ Email: _____

Would you like to receive emails regarding promotions and upcoming events at Orion's Light? _____

Address: _____

Date of Birth: _____ Occupation: _____

Have you had massage work done before? _____

If so, was there anything you particularly liked or disliked about past massage treatments? _____

How did you hear about Orion's Light? _____

Please describe the reason for your visit today: _____

Are you taking any medications? If so, what? _____

Are you pregnant? YES NO Due Date: _____Have you consumed any alcohol within the past 24 hours? YES NO

Please indicate a history of any of the following medical conditions:

- | | | |
|--|--|---|
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> contact lenses | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> accident | <input type="checkbox"/> decreased range of motion | <input type="checkbox"/> neck pain |
| <input type="checkbox"/> acute injury | <input type="checkbox"/> depression | <input type="checkbox"/> nervous tension |
| <input type="checkbox"/> allergies to oils, perfumes | <input type="checkbox"/> diabetes | <input type="checkbox"/> numbness |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> dizziness | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> arthritis, bursitis, gout | <input type="checkbox"/> epilepsy | <input type="checkbox"/> phlebitis, thrombosis |
| <input type="checkbox"/> back pain (low) | <input type="checkbox"/> fever | <input type="checkbox"/> rashes, skin disorders |
| <input type="checkbox"/> back pain (mid) | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> sciatica |
| <input type="checkbox"/> back pain (upper) | <input type="checkbox"/> headaches | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> heart attack | <input type="checkbox"/> seizures |
| <input type="checkbox"/> breast augmentation | <input type="checkbox"/> heart disease | <input type="checkbox"/> shoulder pain |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> hemophilia | <input type="checkbox"/> sprains |
| <input type="checkbox"/> cancer | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> stroke |
| <input type="checkbox"/> carpal tunnel syndrome | <input type="checkbox"/> HIV | <input type="checkbox"/> surgery |
| <input type="checkbox"/> chronic fatigue syndrome | <input type="checkbox"/> irritable bowel syndrome | <input type="checkbox"/> tumors, cysts |
| <input type="checkbox"/> chronic tension | <input type="checkbox"/> joint ache | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> colitis | <input type="checkbox"/> mastectomy | <input type="checkbox"/> whiplash |

 other _____

Please list any therapy/medical care that you are receiving, along with the name of your health care

practitioner(s): _____

Do you follow a regular exercise program? Yes No

Are you under any undue stress? Yes No Please explain: _____

Is there anything else I need to be aware of? _____

I understand that body work is not meant to replace medical examinations, diagnosis, or treatment. If symptoms are severe or persistent, I should consult my health care practitioner immediately.

I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist prescribes neither medical treatment nor pharmaceuticals, nor performs any spinal manipulations.

I understand that the massage therapist must be aware of existing medical conditions. I have stated all my known medical conditions, and take it upon myself to keep the massage therapist updated on my physical health.

I understand that I have the right to terminate a massage therapy session at any time should I feel that the treatment I am receiving is inappropriate and/or not fulfilling the treatment goals set by myself and the massage therapist.

I understand that any inappropriate behavior on my part will lead to the immediate termination of my treatment by the massage therapist, and that payment for the full session will be required.

I understand that when I make an appointment, that time is reserved exclusively for me. I will remit payment for any appointments not cancelled at least 24 hours in advance (barring illness or emergency).

I have read and understand the above conditions and policies.

(Signed)

(Dated)

(Practitioner Signature)