



# Gilstrap & Associates

## Massage Therapy MM#27792

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_ DOB \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 E-mail: \_\_\_\_\_ Referred by: \_\_\_\_\_  
 Occupation (s) \_\_\_\_\_  
 In case of emergency: \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
 Physician name \_\_\_\_\_ Physician Phone ( ) \_\_\_\_\_  
 Health Insurance Carrier \_\_\_\_\_

**Please take a moment to carefully read the following information and inform us where needed. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated (\*). A referral from your primary care provider may be required prior to service being provided.**

<input type="checkbox"/> Yes <input type="checkbox"/> No Do you frequently suffer from stress?	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have diabetes?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you experience frequent headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>Are you pregnant? *</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from arthritis?	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you wear contact lenses?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you wear dentures?	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have high blood pressure?
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you taking high blood pressure medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from epilepsy or seizures?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from joint swelling?	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>Do you have varicose veins? *</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any contagious diseases?	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have osteoporosis?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you bruise easily?
<input type="checkbox"/> Yes <input type="checkbox"/> No Any broken bones in the past two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No Any injuries in the past two years?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have tension or soreness in a specific area?	<b>Please Specify</b> _____
<b>Please specify</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from back pain?
<input type="checkbox"/> Yes <input type="checkbox"/> No <b>Do you have cardiac or circulatory problems? (pacemaker, etc)*</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No Any drug or alcohol use prior to session?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have numbness or stabbing pains? Explain below	<input type="checkbox"/> Yes <input type="checkbox"/> No Are you sensitive to touch/pressure?
<input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had surgery? Explain below.	<input type="checkbox"/> Yes <input type="checkbox"/> No Any areas you would prefer not to be worked on? (Please explain in Comments Area)
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No Are you taking any medications. Please list.
_____	

**Comments or messages for your therapist:** \_\_\_\_\_

Have you ever experienced a professional massage?  Yes  No How frequently do you get them? \_\_\_\_\_  
 What are your massage or bodywork goals? \_\_\_\_\_  
 What kind of pressure do you prefer?  light  medium  firm  I don't have a preference  
**If you answer "yes" to any of the following questions, please explain as clearly as possible, unless otherwise stated.**  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated (\*). A referral from your primary care provider may be required prior to service being provided.**

I understand that the massage/bodywork 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 practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork 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/bodywork practitioners 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/ bodywork 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner'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. I also understand that a credit card number will be held on hand and if any appointment is cancelled less than 24 hours of scheduled appointment time, I will be liable for payment of the scheduled appointment.

Client Signature \_\_\_\_\_ Practitioner Signature \_\_\_\_\_ Date \_\_\_\_\_  
**Consent to Treatment of Minor:** By my signature below, I hereby authorize, Jessie Cloud MA 57064, or \_\_\_\_\_ to administer massage, bodywork, to my child or dependent, \_\_\_\_\_ as they deem necessary.  
 Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_