Leila M Percy Massage

Legal Name: _____ Date:_____

Preferred Name:_____ Date of Birth: _____

Preferred Pronoun: Male__ Female__ They/Them__

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home _____ Cell _____

Emergency Contact: _____ Phone: _____

Email: _____ Occupation: _____

How did you hear about us? _____

Have you received massage therapy before: ___ Yes ___ No If yes, how frequently?_____

Please list any medication you are currently taking:

_____

_____

Have you had a recent major surgical procedure or injury? ____ Yes ____ No
Please list procedure or injury and year:

_____

_____

Please circle your normal stress level:

Low 1 2 3 4 5 High

Please list any stress reduction activities as well as normal exercise habits:

_____

_____

Are you allergic to any Lotions or Oils? ____ Yes ____ No

We use lotions and oils that are nut and scent free.

Circle the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Muscular-Skeletal

Headaches
Joint stiffness/swelling
Spasms/cramps
Broken/Fractured bones
Strains/Sprains
Back, hip pain
Shoulder, neck, arm, hand pain
Leg, foot pain
Chest, ribs, abdominal pain
Problems walking
Jaw pain/TMJ
Tendonitis
Bursitis
Arthritis
Osteoporosis
Scoliosis
Other: _____

Circulator/Respiratory

Dizziness
Shortness of breath
Fainting
Cold feet or hands
Cold sweats
Stroke
Heart condition
Allergies
Asthma
High blood pressure
Low blood pressure
Other: _____

Digestive

Indigestion
Constipation
Intestinal gas/bloating
Diarrhea
Irritable bowel syndrome
Cohn's Disease
Colitis
Other: _____

Nervous System

Numbness/tingling
Fatigue
Sleep disorders
Ulcers
Paralysis
Herpes/shingles
Cerebral Palsy
Epilepsy
Chronic Fatigue Syndrome
Multiple Sclerosis
Muscular Dystrophy
Parkinson's disease
Other: _____

Reproductive System

Pregnancy: Present___ Past____ How many ____
Menopause

Other: _____

Skin

Rashes
Allergies
Athlete's foot
Acne
Impetigo
Hemophilia

Other

Loss of Appetite
Depression
Difficulty concentrating
Diabetes
Fibromyalgia
Post/Polio Syndrome
Tuberculosis
Autoimmune: _____
Cancer: _____
Other: _____

I understand that a massage Therapist does not diagnose disease or illness. I understand that draping will be used at all times. I understand that if I become uncomfortable for any reason that I may ask the Therapist to end the massage session, and they will end the session. I understand that the massage Therapist may end the session for any inappropriate behavior. I have stated all of the conditions that I am aware of, and this information is true and accurate. I will inform the massage therapist of any changes in my status. Client hereby assumes full responsibility for receipt of the massage therapy, and releases and discharges the Therapist from any and all claims, liabilities, damages, actions, or causes of action arising from the therapy received hereunder, including, without limitation, any damages arising from acts of active or passive negligence on the part of the Therapist. To the fullest extent allowed by law.

Client's signature_____ Date_____