Galveston Lotus Therapies

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Client Information (all information is kept strictly confidential)

Please Print

Name____ **Date:** ________________________

Address:____ **City:** ________________________

State: _____ **Zip:** _________ **Date of Birth:** ___/___/______ **Hm Ph: (   )** _____**-** ________

Cell Ph: (   ) _____**-** _________ **E-Mail:**______________________________________

Occupation: ________________________ **Referred By:** __________________________________

In case of emergency: __________________________________ **Phone: (   )** _____**-**_________

General & Medical Information:

If you answer "yes" to any of the following questions, please explain as clearly as possible.

☐ Yes ☐ No Have you ever had a professional massage?

☐ Yes ☐ No Do you experience frequent headaches?

☐ Yes ☐ No Are you pregnant?

☐ Yes ☐ No Are you wearing contact lenses?

☐ Yes ☐ No Are you diabetic?

☐ Yes ☐ No Do you have high blood pressure?

☐ Yes ☐ No If yes to the previous question, is it controlled?

☐ Yes ☐ No Do you suffer from seizure disorders or epilepsy?

☐ Yes ☐ No Do you suffer frequently from stress?

☐ Yes ☐ No Have you ever been diagnosed with Cancer? If yes,

☐ Yes ☐ No have you had lymph nodes removed?

☐ Yes ☐ No Have you had any broken bones in the past two years?

☐ Yes ☐ No Do you have tension or soreness in a specific area?

☐ Yes ☐ No Do you have heart/circulatory problems, or blood clots?

☐ Yes ☐ No Do you suffer from back pain?

☐ Yes ☐ No Do you have numbness or stabbing pains anywhere?

☐ Yes ☐ No Are you very sensitive to touch / pressure in any area?

☐ Yes ☐ No Have you ever had surgery? If yes, please explain in the comments area of this form.

☐ Yes ☐ No Do you have any other medical condition that I should be aware of?

☐ Yes ☐ No Do you have allergies to foods-oils-lotions-fragrances?

Exercise Habits: ____

Comments: ____

____

Medications: ____

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 the service being provided. I understand that 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 therapist so that the pressure and / or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should consult a physician, chiropractor, or other qualified medical specialists for any mental or physical ailment that I am aware of. I understand that massage/bodywork 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/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 forget to do so. I understand that breast massage will not be given without my written consent and that draping will be used during the session. If I am uncomfortable for any reason, I may ask the practitioner to cease the massage session. It is also understood that any 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.

For Women: The therapist will not engage in breast massage without the written consent of the client. **ONLY** If you want a breast massage please check and sign here. ( ) Yes, I want a breast massage Client Signature ______________________

We regret we are unable to accept out of Houston/Galveston area checks. We accept all major credit cards and cash.

Client Signature X ____Date____________________________

Therapist Signature____Date__________________________________

For Massage Therapist Use Only:

1. How long since your last massage? ____

2. What is your favorite part of your body to have massaged?______________________________

3. Is there anything you don't like about massage? ______________________________________

4. Do you prefer light, medium or heavy pressure? ______________________________________

5. Do you have any specific complaints today? ____

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6. Overall, what do you expect from today's massage: Relaxation, Regular Maintenance, Sports Training, Deep Tissue, Work on Pain in a specific area?

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7. Areas of the body to be massaged: face, head, neck, back, shoulders, arms, legs, gluteus. Exceptions: _______________

8. Types of massage techniques to be used: Swedish, INT, CST, LD, Reiki, Hot Stone, Other: ______________________

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