Houston Medical Massage
2990 Richmond Avenue, #630
Houston, TX 77098
(281) 702-7001
halamas.scarbrough@gmail.com

Client Information Form

Name:_____ Home Phone:_____

Address:_____ City/State/Zip:_____

Cell Phone:_____ Work Phone:_____ Birthdate:_____

Email:_____ Occupation:_____

Employer:_____ Emergency Contact:_____

What is the reason for today's visit? (e.g., relaxation, specific discomfort/pain):_____
_____

How did you hear about us? _____

Have you ever had a professional massage before? _____YES _____NO

Are you pregnant or trying to get pregnant? _____YES _____NO

If yes, how far along?_____

Please circle if you have/have had any of the following conditions:

Heart Condition	High Blood Pressure	Vascular/Blood Disorders
Skin Disorders	Immune Disorders	Stomach Disorders
Diabetes	Cancer	Respiratory Disorders
Arthritis	Allergies (including oils/scents)	Headaches
Sciatic Pain	Leg/Foot Pain	Neck/Shoulder Pain
TMJ Syndrome	Neuropathies	Breast Augmentation
Dentures	Herniated/Bulging/Degenerative Discs	Other? Please explain: _____ _____ _

Do you smoke?_____ Drink alcohol?_____ Drink caffeine?_____

Drink soda/pop?_____ Eat chocolate?_____ Use lots of salt?_____

How much exercise/stretching do you do per week (days/duration)?_____

Have you seen any other health professionals for the condition that brought you here today?_____

Do you take any prescription medication? If yes, please list:_____

Do you have any other medical issues, including past surgeries, which I should be aware of before giving you massage therapy? If yes, please describe:_____

_____

Please read the following, and initial and sign below:

___We use only conservative draping during our sessions.

___If you feel uncomfortable for any reason, you may ask to end the session.

___The types of techniques we use in the session, the parts of the body to be massaged, including indications /contraindications, are determined during your initial visit / assessment and are fully explained by your Therapist.

___I understand that massage therapy given here is for the purpose of, but not limited to: Fulfilling a prescription of a treating physician, for a medically necessary condition; for stress reduction, relief from muscular tension, or spasm; or for increasing circulation and energy flow. I understand that the Massage Therapist does not diagnose illness, disease, or any other physical or mental disorder. Massage therapy is not a substitute for medical examinations and/or diagnosis. It is recommended that I see a physician for any physical ailment that I might have.

___Because a Massage Therapist must be aware of existing physical conditions, I have stated all of my known medical conditions and take it upon myself to keep the Massage Therapist updated on my physical health.

___I will respect the time of my Massage Therapist(s) and other clients. I agree to come to my scheduled appointments promptly, barring any unforeseen emergency. I understand that if I cancel later than 4 hours prior to my appointment, I will have to pay HALF the cost of my appointment. If I NO SHOW, I will have to pay the FULL price of the appointment.

Client Signature: _____Date:_____

Therapist Signature:_____Date:_____