



**- CLIENT FORM -**

*All information provided is confidential*

Here at Innisfree, we would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your therapy session, please let us know. Thank you!

Name \_\_\_\_\_

Address \_\_\_\_\_  
Street \_\_\_\_\_ Apt \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ E-mail \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_

Occupation \_\_\_\_\_

Referred by \_\_\_\_\_

Primary Physician \_\_\_\_\_

Have you ever received massage therapy? Y \_\_\_\_\_ N \_\_\_\_\_

If yes, what type of massage experienced? \_\_\_\_\_

Are you currently under the care of a health practitioner, MD, Chiropractor, Occupational

Therapist / (Circle One) Y \_\_\_\_\_ N \_\_\_\_\_

If yes, please give details \_\_\_\_\_

Are you taking medication? Y \_\_\_\_\_ N \_\_\_\_\_

If yes, please describe \_\_\_\_\_

Do you have any allergies to nuts, oils, etc Y \_\_\_\_\_ N \_\_\_\_\_

If yes, please list your allergies \_\_\_\_\_

Are you pregnant? \_\_\_\_\_

What are your exercise habits? \_\_\_\_\_



Innisfree

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PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE OR HAD A HISTORY OF IN THE SPACE BELOW:

- |                         |                         |                       |
|-------------------------|-------------------------|-----------------------|
| Accidents               | Depression              | Osteoporosis          |
| Allergies               | Digestion Problems      | Phlebitis/Blood Clots |
| Arthritis               | Dizziness / Fainting    | Pins/Pacemakers       |
| Anxiety                 | Endocrine Issues        | Pregnancy             |
| Asthma                  | Fatigue                 | Psychiatric           |
| Bleeding/Bruising       | Fibromyalgia            | Recent Surgery        |
| Blood Pressure Problems | Headaches               | Respiratory           |
| Bursitis                | Hepatitis               | Seizures/Epilepsy     |
| Cancer                  | Hernia                  | Skin Problems         |
| Cardiac Issues          | Joint Problems          | Smoker                |
| Circulation Problems    | Kidney /Urinary         | Stress                |
| Cold Sweats             | Liver / Gall Bladder    | Ulcer                 |
| Contact Lenses          | Muscle Sprains/ Strains | Varicose Veins        |
| Colitis                 | Nervous Tension         | Vertebral/Disks       |

DETAILS: \_\_\_\_\_  
\_\_\_\_\_

PLEASE INDICATE ANY AREAS YOU ARE FEELING DISCOMFORT AND EXPLAIN ANY CONDITIONS THAT YOU CIRCLED IN THE SPACE PROVIDED.

\_\_\_\_\_  
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## MASSAGE THERAPY INFORMED CONSENT

I, \_\_\_\_\_, understand that massage therapy given here is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch.

The general benefits of massage, possibly massage contraindications and the treatment procedures have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I currently work with my Primary Caregiver for any conditions I may have.

I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy. I have informed the massage therapist of all my known physical conditions, medical conditions, and medications, and will keep the massage therapist updated on any changes.

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*Client's Signature*

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*Date*