Name _____Date_____
Best phone number to be reached at _____
Address_____
City/State/Zip _____
Email _____ Date of Birth _____
Occupation _____
Emergency Contact _____ Phone Number_____
How did you hear about us? Newspaper ad____ Web____ Facebook____ Noticed sign____ Other_____
Did a friend refer you? Yes no If so, who may we thank ?_____

Lotta Knots Massage

The following information will be used to help plan safe and effective massage sessions.
Please answer the questions to the best of your knowledge.

1. Have you had a professional massage before? Yes No
2. Do you have any difficulty laying on your front, back, or side? Yes No

   If yes, please explain _____
3. Do you have any allergies or sensitivity to SMELLS/AROMAS, oils, lotions, or ointments? Yes No
4. Do you sit for long hours at a workstation, computer, or driving? Yes No

   If yes, please describe _____
5. Do you perform any repetitive movement in your work, sports, or hobby? Yes No

   If yes, please describe _____
6. Is there an area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

   If yes, please identify_____
7. Do you have any particular goals in mind for this massage session? Yes No

   If yes, please explain _____
8. Are you currently under medical supervision? Yes No

   If yes, please explain_____
9. Are you currently taking any medication? Yes No

   If yes, please list_____

Medical History
In order to plan a massage session that is safe and effective,
I need some general information about your medical history.

Continued on next page

10. Please check any condition listed below that applies to you:

( ) contagious skin conditions
( ) open sores or wounds
( ) easy bruising
( ) recent accident or injury
( ) recent fracture
( ) artificial joint
( ) sprains/strains
( ) current fever
( ) swollen glands
( ) allergies/sensitivity
( ) heart condition
( ) high / low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) atherosclerosis
( ) sciatic problems
( ) recent surgeries
( ) phlebitis
( ) deep vein thrombosis/blood clots
( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
( ) osteoporosis
( ) epilepsy
( ) headaches/migraines
( ) cancer
( ) diabetes
( ) decreased sensation
( ) back/neck problems
( ) Fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) tennis elbow
( ) pregnancy If yes, how far along? _____
( ) rotator cuff issues

Please explain any condition that you have marked above _____
_____
_____
_____

11. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____
_____
_____

Draping will be used during the session – only the area being worked on will be uncovered.
Clients under the age of 17 but be accompanied by a parent or legal guardian during the entire session.
Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, _____ (print name) understand that the massage 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 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 that I diagnose, prescribe, or treat any physical or mental illness, and that nothing said during the course of the session given should be construed as such. Because massage 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of Client_____ Date_____

Signature of Massage Therapist_____ Date_____