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Client Release Form

(Please Print Clearly)

Name: _____ Email: _____

Address: _____

City: _____State: _____ Zip: _____

Home #: _____ Cell #:_____ Occupation: _____

Date of Birth: _____ Referred by: _____

List any medications you are taking: _____

Are you pregnant? _____ How many months? _____ When was your last massage? _____

Reason for your visit: _____

United Healthcare Oxford I.D. # _____

Please check if you have any of the following:

Headaches		Diabetes		Chronic Pain	
Skin Disorders		Lower Back Pain		Osteoporosis	
Cancer		T.M.J. Syndrome		Neck / Spine Injury	
High Cholesterol		Low Blood Pressure		Sports Injury	
Heart Ailment		High Blood Pressure		Varicose Veins	

Emergency contact: _____ Phone: _____

PLEASE READ THE FOLLOWING AND SIGN BELOW:

I understand that massage therapy is not a replacement for medical care and that no diagnosis will be made. I have informed the massage therapist of all my known physical and medical conditions and agree to keep the massage therapist updated on any changes.

You will be required to pay 100% of the service charge when a 24 hour notice is not provided.

Client Signature: _____ Date: _____