Oasis Massage for Women

Name _____ Phone (____)_____ Date of birth: _____/_____/_____

Address _____ City _____ State _____ Zip_____

Email _____ Check to receive occasional promotional emails: _____

Occupation _____ Referred by: _____

In case of emergency: _____ Phone (____) _____

Please check any that apply. Any condition marked will be discussed prior to treatment.

_____ Allergies
_____ Arthritis/Osteoporosis
_____ Athletes Foot
_____ Blood Clots/DVT
_____ Broken Bone
_____ Cancer _____
_____ Chronic Pain _____
_____ Circulatory Conditions
_____ Diabetes
_____ Epilepsy/Seizures
_____ Headaches/Migraines
_____ Heart Condition
_____ High/Low Blood Pressure
_____ Medicated Patch for _____
_____ Muscle Injury: Sprain/Strain _____
_____ Pregnancy-Trimester? _____
_____ Recent Surgery_____
_____ Skin Sensitivity
_____ Tingling/Numbness _____
_____ Varicose Veins

If you are currently under the care of a physician or on medication, please provide name and purpose of care. _____

Do you have tension/soreness in a specific area? Please specify:_____

Previous massage experience? Yes _____ No _____ Last treatment? _____

What kind of pressure do you prefer? ▪ light ▪ medium ▪ firm

On a scale of 1-10, please rate: Pain level: _____ Stress level: _____

I 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 practitioner 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 of which I am aware. I understand that massage practitioners are not qualified to perform spinal/ 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 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 fail to do so. I also understand that any illicit or 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.

Client Signature _____ **Date** _____

Practitioner Signature _____ **Date** _____