ACUJIN
HOLISTIC THERAPIES

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NAME:_____ PHONE:_____ DOB:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

EMAIL:_____ REFERRED BY:_____

EMERGENCY CONTACT:_____ PHONE:_____

OCCUPATION:_____ MALE___ FEMALE___ PHYSICIAN:_____

PLEASE TAKE A MOMENT TO CAREFULLY READ THE FOLLOWING INFORMATION, AND SIGN WHERE INDICATED. IF YOU HAVE A SPECIFIC MEDICAL CONDITION AND/OR SYMPTOMS, MASSAGE/BODYWORK MAY BE CONTRAINDICATED. A REFERRAL FROM YOUR PRIMARY HEALTHCARE PROVIDER MAY BE REQUIRED PRIOR TO SERVICES BEING PROVIDED.

HAVE YOU EVER EXPERIENCED A PROFESSIONAL MASSAGE / BODYWORK SESSION? YES___ NO___

WHAT ARE YOUR MASSAGE / BODYWORK GOALS?_____

WHAT KIND OF PRESSURE DO YOU PREFER? ___LIGHT ___MEDIUM ___HARD

PLEASE LOOK OVER THE FOLLOWING LIST OF HEALTH DISORDERS AND CIRCLE ANY AND ALL THAT APPLY. IF YOU SELECT ANY, PLEASE EXPLAIN AS CLEARLY AS POSSIBLE.

BONE OR JOINT DISEASE
RASHES
BROKEN / FRACTURED BONES
CONSTIPATION
LOW BACK / HIP / LEG PAIN
HEADACHES / HEAD INJURIES
SPASMS / CRAMPS
VARICOSE VEINS
DIABETES / TYPE
HIGH/LOW BLOOD PRESSURE
DRUG / ALCHOHOL DISORDER
BREATHING DIFFICULTIES
NICOTINE / CAFFEINE ADDICTION
FIBROMYALGIA / PAIN SYNDROME
ALLERGIES
BURSITIS
WARTS
NECK / SHOULDER / ARM PAIN
IRRITABLE BOWEL SYNDROME
HERPES / SHINGLES
TMJ / JAW PAIN
DEPRESSION
CANCER / TUMORS
INFECTIOUS DISEASES
EATING DISORDER
SINUS PROBLEMS
HEART CONDITIONS / DISEASE
CHRONIC PAIN
TENDONTIS
ATHLETES FOOT
ARTHRITIS
DIVERTICULITIS
FATIGUE
SLEEP DISORDER
ANXIETY
ENDOMETRIOSIS
PMS/PMDD
LYMPHEDEMA
BRUISE EASILY
BLOOD CLOTS
ASTHMA

COMMENTS / SPECIFIC AREAS OF SORENESS?_____

_____

I UNDERSTAND THAT THE MASSAGE/BODYWORK I RECIEVE IS PROVIDED FOR THE PURPOSE OF RELAXATION AND RELIEF OF MUSCULAR TENSION. IF I EXPERIENCE PAIN OR DISCOMFORT DURING THE SESSION, I WILL IMMEDIATELY INFORM THE PRACTITIONER SO THAT THE PRESSURE AND/OR TECHNIQUE MAY BE ADJUSTED TO MY LEVEL OF COMFORT. I FURTHER UNDERSTAND THAT MASSAGE / BODYWORK SHOULD NOT BE CONSTRUED AS A SUBSTITUTE FOR MEDICAL TREATMENT. I UNDERSTAND THAT MASSAGE / BODYWORK PRACTITIONERS ARE NOT QUALIFIED TO DIAGNOSE, PRESCRIBE, OR TREAT PHYSICIAL OR MENTAL ILLNESS, AND THAT NOTHING SAID IN THE COURSE OF THE SESSION SHOULD BE CONSTRUED AS SUCH. BECAUSE MASSAGE / BODYWORK SHOULD NOT BE PERFORMED UNDER CERTAIN CONDITIONS, I AFFIRM THAT I HAVE STATED ALL MY KNOWN CONDITIONS, AND HAVE 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 FORGET TO DO SO. I ALSO UNDERSTAND THAT ANY ILLICIT OR SEXUALLY SUGGESTIVE REMARKS MADE BY ME WILL RESULT IN IMMEDIATE TERMINATION OF THE SESSION, AND I WILL BE LIABLE FOR PAYMENT OF THE SCHEDULED APPOINTMENT. I UNDERSTAND THAT IF I CANCEL AN APPOINTMENT WITHIN 24 HRS OF THE SCHEDULED APPOINTMENT TIME, I AM RESPONSIBLE FOR THE FULL VALUE OF THE SESSION.

CLIENT SIGNATURE:_____ DATE:_____