

Harmonious Touch

Tawny Moreno, LMT

Client Information

Name: _____ Date: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Work/CellPhone _____

Occupation: _____ Birth date: _____

Referred by: _____

Primary Care Physician: _____ Phone: _____

Chiropractor: _____ Phone: _____

Emergency contact: _____ Phone: _____

MEDICAL CONDITIONS

Please check what areas apply to you.

Cancer, tumors

Stroke, blood clots

Heart disease

Hemophilia

High blood pressure

Seizures

Diabetes

Serious accidents:when? _____

Migraines/headaches

Recent surgery

Allergies*Please list _____

Recent cold/flu

Fibromyalgia

Asthma

Vaccinations/recent injections*

Carpal tunnel

Osteoporosis

Varicose Veins

Plantar warts

Jaw Pain/TMJ

Tendonitis

Ulcers

Bursitis

Communicable/contagious conditions

Please list other existing health conditions not listed:

Are you currently pregnant? What trimester are you in?

Have you ever had a professional massage before? Was it beneficial?

Please read the following carefully and sign and date below:

I give my permission for Tawny Moreno, Licensed Massage Therapist, to contact my primary care provider at any time to discuss proper treatment. yes no (please initial).

I understand that the massage/bodywork 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, or any sessions that I may have in the future, I will immediately inform the practitioner so that the pressure and/or stroke may be adjusted to my comfort level. I further understand that massage or bodywork 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/bodywork practitioners are not qualified to perform spinal or skeletal adjustments. I affirm that I have stated all my known medical conditions, and have answered accordingly. I agree to keep the practitioner updated as to any changes in my medical profile and I understand that there shall be no liability on the practitioners part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances will result in immediate termination of the session and I will be liable for the payment of the scheduled appointment.

I AGREE TO PAY FOR ANY MISSED APPOINTMENTS, AND \$25 FOR ANY RETURNED CHECKS.

Signature: _____ Date: _____

Email address: _____