Om Chakra Client Information

This information is necessary for us to provide you with a massage session that best meets your needs. Please take the time to answer all of the questions below as accurately as possible. The information you provide is strictly confidential.

General Information

Name:_____ Date of Initial Visit:_____

Address:_____ City:_____ State:____ Zip:_____

Date of Birth:____ / ____ / _____ Gender: Male____ Female____

Home Phone: (____)_____ Cell: (____)_____ Work: (____)_____

Occupation: _____ Email: _____

Emergency Contact: _____ Phone: (____)_____

How did you hear about the Clinic? _____

Have you ever received a professional Massage? Yes____ No____ Type: _____

Medical Information

Are you currently under the care of a physician for any reason? Yes____ No ____

If yes, please explain:_____

Physicians' Name:_____ Phone: (____)_____

With certain medical conditions and symptoms, massage should not be performed and permission from your physician may be required prior to service being provided.

Do we have permission to contact your physician? Yes____ No____

Are you currently taking any medications? Yes____ No____

If yes, please list them including any vitamins and herbal supplements

_____

_____

Are you pregnant? Yes____ No____ If so, how far along are you?_____

Please check any medical conditions that apply:

___ Abscess/Open Sores
___ Allergies
___ Arteriosclerosis
___ Asthma
___ Bruising
___ Headaches
___ Stomach Ulcers
___ Surgeries
___ Varicose Veins
___ HIV/AIDS
___ Cancer – Type:_____

___ Digestive Problems
___ Epilepsy
___ Fibromyalgia
___ Fluid Retention
___ Fractures/breaks
___ Skin Sensitivity
___ Chronic Fatigue Syndrome
___ Depression
___ Diabetes
___ Other: Please explain: _____

___ Implants
___ Menstrual Problems
___ Osteoarthritis
___ Osteoporosis
___ Rheumatoid Arthritis
___ Heart Disease
___ Hepatitis B or C
___ Herniated Disc(s)
___ Hypertension

Diagnosis Date: _____ Last Treatment:_____

Lifestyle Information:

Do you exercise? Yes____ No_____ How often and what type? _____

Do you use? ___ Tobacco ___ Alcohol ___ Caffeine

How much water do you drink daily? _____

How would you rate your stress level on a scale of 1 (Lowest) and 10 (Highest)? _____

Where do you hold tension in your body? _____

I understand that the massage I receive is provided for the basic purpose of relaxation and the relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure/stroke may be adjusted to my level of comfort. I further understand that massage should not be performed under certain medical conditions. I affirm that I have stated all of my known conditions and answered all of the above questions honestly. I agree to keep Om Chakra updated as to any changes in my medical/health status. I assume all legal responsibilities for my health and well-being. I release Om Chakra from any and all present and future responsibility. I understand that Om Chakra reserves the right to terminate my session if deemed necessary.

Client Signature:_____ Date:_____