Astrid Hutchison Massage

Name: ______________________________ Date: ____________________

Birthday:_________ Occupation ___________________________

Home Address:____

City:_________________________ State: ____ Zip:____________

Cell Phone Number:______________________

Emergency Contact Name/Number:_____________________________________

Email Address: ____

How did you hear about me?____

Have you had professional massage before? Y/N

If Yes, how often do you receive massage therapy?________________________

Please list any allergies____

Do you sit for long periods of time at computer or driving? Y/N

If Yes, please indicate____

Do you perform any repetitive movement in work, sport or hobby? Y/N

If Yes, please explain____

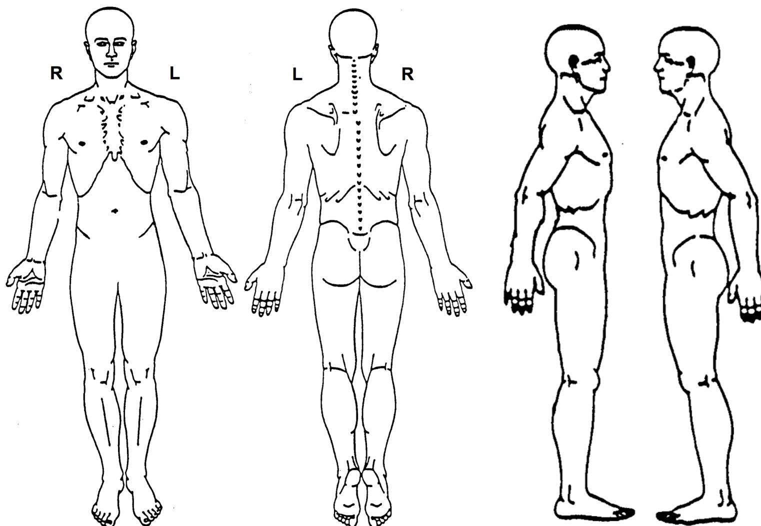
Do you experience stress often in your life? Y/N __________________________

Effects: ( )Muscle Tension ( )Anxiety ( )Insomnia ( )Irritability

( )Other____

Please identify particular areas of the body you are experiencing tension, stiffness, pain and other discomforts?____

Please mark your conditions, areas of concern and/or pain.



Astrid Hutchison Massage

What are your goals/intentions for this massage session?________________________________

____

Do you have any of the following today:

[ ] Cold or Flu	[ ] Are you pregnant? Due:__________________
[ ] Open cuts/sores	[ ] Skin rash-where:________________________

Medical History: Have you ever had/do you have any of the following:

[ ] Diabetes	[ ] High / Low BP: ________________________	
[ ] AIDS/HIV	[ ] Blood Clot/DVT	[ ] Kidney Disease
[ ] Constipation	[ ] Lupus/ Crohns / Lymes	[ ] Stroke/CVA / TIA
[ ] Fibromyalgia Syndrome	[ ] Liver Disease	[ ] Neuropathy/Numbness
[ ]Chronic Fatigue Syndrome	[ ] Heart Attack/MI	[ ] Seizures
[ ] Cancer/Tumor/Chemo	[ ] Allergies:	[ ] Other

Other: ____

Are you now under medical/therapeutic treatment? Yes / No

If Yes, please explain____

Please list medications you may be taking:

Please list any surgeries you have had: ____

Please list any additional comments regarding your health and wellbeing: ________________

____

If I experience any pain or discomfort during this session, I will immediately inform the therapist 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 or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I understand that, because massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage and bodywork from this practitioner. I also acknowledge that massage is not sexual and that I will not engage in inappropriate conversation or behavior that undermines my therapist's trust.

Signature:____ Date:___________