Kneaded By Jeannie™

"Bodies Love to be Kneaded"℠

Jeannie L. Claycomb, LMT

LICENSED MASSAGE THERAPIST

INITIAL CLIENT VISIT INFORMATION & RELEASE (All blanks must be filled-in.)
Thank you for your interest in our Therapeutic Massage Services. Please print out this form, fill in the information below, and bring it with you to your first visit. Or, fax your completed form to 630.226.1265.

Name:_____Phone: (_____) _____ Date of Birth: _____

Address:_____ City/State: _____

In Case of Emergency: _____ Phone: (_____) _____

Email Address: _____

GENERAL & MEDICAL INFORMATION

Occupation: _____ Age: _____ ❍ Male ❍ Female Your Physician: _____

Your Physician's Phone Number: (_____) _____ Health Insurance Carrier: _____

If yes, are you currently under a doctor's supervision for this ailment? ____ Yes ____ No

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

If you answer "yes" to any of the following questions, please explain as clearly as possible. (Use a separate piece of paper if necessary.)

❑ Yes ❑ No Do you frequently suffer from stress?
❑ Yes ❑ No Do you have diabetes?
❑ Yes ❑ No Do you experience frequent headaches?
❑ Yes ❑ No Are you pregnant?
❑ Yes ❑ No Do you suffer from arthritis?
❑ Yes ❑ No Do you wear contact lenses?
❑ Yes ❑ No Do you wear dentures?
❑ Yes ❑ No Do you have high blood pressure?
❑ Yes ❑ No If "yes" to previous question, are you taking medication for this?
❑ Yes ❑ No Do you have epilepsy or experience seizures?
❑ Yes ❑ No Do you experience joint swelling?
❑ Yes ❑ No Do you have varicose veins?
❑ Yes ❑ No Do you have any contagious disease?
❑ Yes ❑ No Do you have osteoporosis?
❑ Yes ❑ No Do you have any allergies?
❑ Yes ❑ No Do you bruise easily?
❑ Yes ❑ No Have you had any broken bones in the past two years?
❑ Yes ❑ No Have you been in an accident or suffered any injuries in the past two years?
❑ Yes ❑ No Do you have tension or soreness in a specific area? Please specify: _____
_____
❑ Yes ❑ No Do you have cardiac or circulatory problems?
❑ Yes ❑ No Do you suffer from back pain?
❑ Yes ❑ No Do you have numbness or stabbing pains anywhere?
❑ Yes ❑ No Are you sensitive to touch or pressure in any area?
❑ Yes ❑ No Have you had surgery? Explain below.
❑ Yes ❑ No Do you have any other medical condition or are you taking any medications I should know about?

Comments:_____

_____

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 the 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 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 medical or physical ailment that I am aware of. I understand that massage/bodywork practitioners are not qualified to perform spinal or 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/bodywork 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. 24 hour appointment cancellation notice is required or full payment will be due. Couples appointments require a 48 hour notice to avoid being charged in full. Personal checks accepted. $35 fee for any returned check.

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage, bodywork or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian: _____ Date: _____