Client Information:

Name:	Date:
Email:	Phone:
Address:	Date of Birth:
Emergency Contact Name and Phone:	
Referred by:	

Massage Information:

Have you received a massage before?				
Have you received cupping treatments before?				
What kind of pressure do you prefer?				
What are your expected outcomes for receiving massage?				
How do you feel today?				
Current medications:				
Are you pregnant?				
Please circle parts of your body you do not want touched:				
Feet	Legs	Buttocks	Lower Back	Upper Back
Shoulders	Neck	Arms	Hands	Stomach
Face	Ears	Head		

Health History:

Have you had any injuries or surgeries in the past that may influence today's treatment?
Are you diagnosed with any health conditions? Please explain:
Do you have any medical condition that would make therapeutic massage inadvisable?
Do you have any medical condition that would make cupping treatments inadvisable?

Other Comments:

Consent for Treatment:

If I experience any pain or discomfort during this 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/bodywork/cupping 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/cupping 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/cupping 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. Understanding all of this, I give my consent to receive care. If I am the parent/guardian of a minor, I will be present throughout the duration of the treatment.

Client Signature:	**Date:**
Parent/Guardian Signature (in case of minor):	**Date:**

Cancellation Policy
I understand that unanticipated events happen occasionally in everyone's life. In my desire to be effective and fair to all clients, the following policies are honored:

24 hour advance notice is required when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give 24 hours advance notice you will be charged the full amount of your appointment. This amount must be paid prior to your next scheduled appointment.

Late Arrivals
If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Regardless of the length of the treatment actually given, you will be responsible for the session.

I look forward to serving you!

Anne-Christin Trost, PhD, CMT

916.520.4013 | trost@massagetherapy.com | www.trost.massagetherapy.com