Client Wellness Information

Leo Feraer-Oporto MS, BSB, RN, LMT, LMBST, CMMT
Registered Nurse Massage Therapist

El Aephau
Massage Therapy

Name:	Address:
Home Phone:	City:
Cell Phone:	State:
Work Phone:	Zip:
E-mail:	Occupation:

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, 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 mental or physical ailment of which I am aware. 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.

Client: ____________________ *Date:* ____________________

Therapist: ____________________ *Date:* ____________________

Please help me ensure a safe and comfortable massage experience by providing the following information.

Check all that applies and explain below:

- ☐ Asthma
- ☐ Blood clots
- ☐ Cancer
- ☐ Diabetes
- ☐ Fibromyalgia/Lupus
- ☐ Headaches
- ☐ Heart problems
- ☐ High/ low blood pressure
- ☐ History of stroke
- ☐ Immune system deficiency
- ☐ Implants
- ☐ Infections
- ☐ Insomia (Sleep disturbances)
- ☐ Lyme disease
- ☐ Myasthenia Gravis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pain (Joint, muscle, disc, nerve)
- ☐ Rheumatoid arthritis
- ☐ Thyroid issues
- ☐ Varicose veins

Explanation(s): ____________________

List and Explain: Surgeries; Injuries; Illnesses: ____________________

Allergies: (to scents, nuts, menthol, etc.)____________ Heat/Cold Sensitivity? ☐Yes ☐No Pregnant?: ☐ Yes ☐ No ☐ N/A

Current Skin Conditions: (bruises, rashes, acne) ____________________

Have you experienced any of the following in the past 30 days? Pain, numbness, tingling, swelling or fatigue? ☐Yes ☐No

Explain: ____________________

Medications:(You are taking or have taken in the past 7 days) ____________________

Describe your diet and Exercise: ____________________

____________________ Tobacco: ☐Yes ☐No Alcohol: ☐ Yes ☐ No ☐ Occasional

List daily activities that are inhibited by your current condition: ____________________

Are you comfortable with having therapeutic massage on the following areas? Gluteals: ☐ Yes ☐No Abdomen: ☐ Yes ☐No

Pectorals: ☐Yes ☐No Hands: ☐ Yes ☐No Feet: ☐ Yes ☐ No Face: ☐ Yes ☐No Scalp: ☐ Yes ☐ No

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Pilot Session Intake: ____ /____ /____

Interview Notes:
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60 - 90 - 120 mins. at ___- to ___- am / pm

Massage Plan:
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