Listening Touch

Welcome! Thank you for taking the time to fill out this form. All information will be kept confidential.

Name _____Date _____
Address _____City _____
State_____ Zip_____ email_____
Gender: O male O female O transgender O m-t-f O f-t-m O other
Subscribe to monthly email newsletter? O yes O no

Date of Birth _____
O Home Phone_____
O Work Phone_____
O Cell Phone_____
(Please check your preferred phone)

Occupation _____ Emergency Contact Name_____
Employer _____ Emergency Contact Phone_____
Are you currently under a doctor's care? Yes / No (if yes, please describe)_____
Primary Physician or Healthcare Provider: _____ Healthcare Provider's Phone _____
How did you find Listening Touch Massage?_____
Have you received professional massage or bodywork before today? Yes / No Favorite style/technique(s)_____
Do you exercise? Yes / No How often?_____ What type?_____
Are you currently taking any ***prescribed medications*** or ***pain medications***? Yes / No (If yes, please list, along with condition)
_____
_____
Have you had any **major surgeries or injuries**? Yes / No If yes, please make note of them in the space provided with date(s):
_____
_____
What are your major complaints and symptoms today? _____
What are your needs and expectations for this treatment? _____
Do you have allergies to nuts, lotions, oils or creams? Yes or No If yes, please describe:_____
Do you have any of the following? please circle: Contacts Dentures Hearing aids Wig Pacemaker IV/Port Bone pin/s Spinal rods

Please check any of the following conditions that you have a history of or currently have:

Blood, Heart and Circulatory
O Bruise Easily O Anemia
O Varicose veins O Swelling/Edema
O Lymphedema Location:_____
O Lymph node removed or radiated
O Blood Clots O Stroke O Pace-maker
O Low Blood Pressure O High BP
O Heart Condition _____

Chronic Pain / tension
O Back o lower o middle o upper
O Neck O Shoulders O Hip/s
O Knee/s O _____

Bone, Joint & Muscle
O Broken/Dislocated_____
O Disc o bulging o herniated_____
O Arthritis Location(s): _____
O Tendonitis/Bursitis _____
O Carpal Tunnel Syndrome

Do you suffer from:
O Headaches o Migraine o Tension
O Sleeping Problems O Anxiety O Depression
O Other mental health_____
O Digestive Problems_____

Women Only:
O Are you pregnant? yes / no Due Date:____
O Previous Pregnancies_____
O PMS/PMDD O Menopausal Symptoms
O Breast Pain O Infertility
O other_____

Men Only: O Prostate Problems

Viral/ Skin Problems
O Rash O Fungus O Warts
Location: _____
O Shingles/Herpes
O other_____

Respiratory
O Seasonal Allergies O Asthma
O Smoking History O Sinus Problems
O other_____

Auto Immune, Nervous, Endocrine
O Diabetes o Type I o Type II
O Fibromyalgia O Multiple Sclerosis
O HIV O Lupus
O Neuropathy O Rheumatoid Arthritis
O other_____

Cancer -Location(s) and date(s):
_____
_____
O Surgery _____
O Chemo _____
O Radiation_____
O Other _____
_____

Is there any condition not listed above that your massage practitioner should be aware of? If yes, please list: _____
_____

Informed Consent I, the undersigned agree to receive massage from Listening Touch, and I understand that massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, and improve circulation and provide a positive experience with touch. I am aware that my massage practitioner does not diagnose disease or illness, prescribe medications or perform skeletal manipulations. I comprehend that I **may terminate a massage session at any time** if I feel uncomfortable with the course of treatment. Therapist reserves the right to end session in the case of any inappropriate behavior. The benefits of massage therapy, possible contraindicating factors, and a treatment plan have been explained to me. I realize that the health benefits of massage therapy are not guaranteed, nor is massage therapy intended to be a substitute for supervised medical treatment by a doctor. I have informed my massage practitioner of all my known medical conditions and I agree to inform my practitioner of any changes in my health as they occur. I hereby assume full responsibility for receipt of the massage therapy, and release and discharge Therapist from any and all claims, liabilities, damages, or causes of action arising from the therapy received hereunder, including, without limitation, any damages arising from acts of active or passive negligence on the part of the Therapist, to the fullest extent allowed by law.

Cancellation Policy I understand that this time has been reserved for me, and all appointments MUST be cancelled within 24 hours or I will pay the FULL amount of the service I was scheduled for. If there is an emergency, I understand that the cancellation fee will be **50% of the amount** of the service I was scheduled for. Thank you for understanding.

Initial here_____

I acknowledge receipt and comprehension of the Listening Touch policies for services and agree to the policies stated above.

Client's Signature: _____ **Date:** _____

Listening Touch