

The Gentle Place Massage

Appts: 508-788-7300

Cell: 508-277-9665



79 Main St., Suites 104-106

Framingham, MA 01702

www.TheGentlePlace.com

Today's Date: _____

name _____

address _____

city, state , zip _____

home phone _____ work phone _____

cell phone _____ email _____

date of birth _____ marital status _____

occupation _____ referred by _____

emergency contact name _____ emergency contact phone _____

physician's name _____ physician's phone _____

Massage Experience

Have you had a professional massage before? Y N

Type(s)? _____ Frequency _____

Goals for Treatment: _____

Do you exercise regularly and/or participate in any sports? Y N
Explain: _____

Do you perform any repetitive movement in your work, sports or hobby? Y N Explain: _____

Do you sit for long hours (workstation, computer, driving?) Y N
Explain: _____

What is the level of stress in your life? 1 2 3 4 5 6 7 8 9 10
Explain: _____

Please list any areas of tension, discomfort or pain: _____

Recent injury, surgery, or areas of inflammation? Y N
Explain: _____

Do you have sensitive skin? Y N

Do you have any allergies to oils, lotions or ointments? Y N
Explain: _____

Any other known Allergies: _____

List any medications you are currently taking: _____

Health History

___ Musculoskeletal

- ___ Bone or joint disease
- ___ Tendonitis/Bursitis
- ___ Arthritis/Gout
- ___ Jaw Pain (TMJ)
- ___ Lupus
- ___ Spinal Problems
- ___ Migraines/Headaches
- ___ Osteoporosis

___ Circulatory

- ___ Heart Condition
- ___ Phlebitis/Varicose Veins
- ___ Blood Clots
- ___ High/Low Blood Pressure
- ___ Lymphedema
- ___ Thrombosis/Embolism

___ Respiratory

- ___ Breathing Difficulty
- ___ Asthma
- ___ Emphysema
- ___ Allergies, specify: _____
- ___ Sinus Problems

___ Nervous System

- ___ Shingles
- ___ Numbness/Tingling
- ___ Pinched Nerve
- ___ Chronic Pain
- ___ Paralysis
- ___ Multiple Sclerosis
- ___ Parkinson's Disease

___ Reproductive

- ___ # Pregnancies
- ___ Currently Pregnant, stage _____
- ___ Ovarian/Menstrual Problems
- ___ Prostate

___ Skin

- ___ Allergies, specify: _____
- ___ Rashes
- ___ Cosmetic Surgery
- ___ Athlete's Foot
- ___ Herpes/Cold Sores

___ Digestive

- ___ Irritable Bowel Syndrome
- ___ Bladder/Kidney Ailment
- ___ Colitis
- ___ Crohn's Disease
- ___ Ulcers

___ Psychological

- ___ Anxiety/Stress Syndrome
- ___ Depression

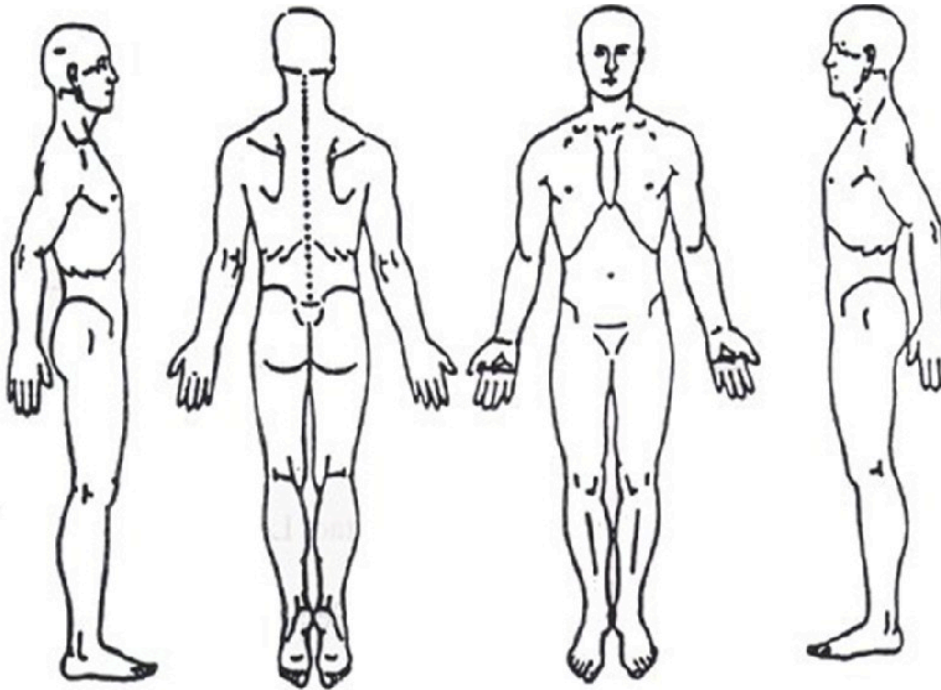
___ Other

- ___ Cancer/Tumors
- ___ Diabetes
- ___ Drug/Alcohol Use
- ___ Tobacco Use
- ___ Contact Lenses
- ___ Dentures
- ___ Hearing Aids

Any other medical condition(s) not listed

Please explain any of the conditions that you have marked above :

On the drawings below, please mark w/ an X the areas where you are currently experiencing pain, tension or discomfort.



Informed Consent and Practice Policies

I understand that Massage Therapy/Bodywork provided by the massage therapists at The Gentle Place, is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Professional draping will always be used during the session, and only the area being worked on will be uncovered.

If I experience any pain or discomfort during the 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/bodywork should not be construed as a substitute for medical treatment or medication, 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 am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy. 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 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. All client information shall be held in strictest confidence except where required by law.

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.

I also understand that 24-hour notice is required if I am unable to make my scheduled appointment (emergencies excluded), otherwise I am financially responsible for the booked appointment.

I have read the above, and agree to abide by the policies.

Client Signature

Date