SOUL HEALING
NEW CLIENT INFORMATION & RELEASE FORM

Please fill out this form carefully. Your answers will better help me to meet your needs and also assist with your happy and satisfying experience.

First Name: Last Name:

Mailing Address:

City: State: Zip Code:

Email: Phone:

Name you prefer to be called if different from your first name:

Your Occupation:

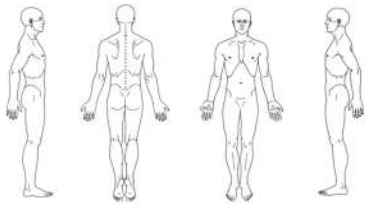
Is this your first professional Massage?

- Yes
- No

General Medical Information

Check the box if you have had any recent problems with the following:

- Arthritis
- Bursitis
- Back pain
- Neck pain
- Arms / Hands
- Hips / Legs / Feet
- Headaches
- Swollen joints
- Fibromyalgia
- High blood pressure
- Low blood pressure
- Poor circulation
- Anemia
- Stroke
- Chest pain
- Seizures / Convulsions
- Heart Conditions
- Constipation
- Diabetes
- Sinus/Allergies
- Hematomas
- Phlebitis
- Vericose Veins
- Cancer
- Skin conditions
- Pregnant ____# months
- Menstrual pain
- Warts
- Athlete's feet



Please circle any areas of pain, injury, tension and areas with restricted movement

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Have you recently suffered an acute injury?

Have you had any recent surgery?

Do you have any medical conditions I should be aware of?

Do you have any problem areas / injuries?

Do you wear contacts? Do you take any prescription medications?

Where do you carry your stress/tension?

What is your biggest stressor?

Name one thing that you'd like to change to release your stress?

Do you have any allergies?

Yes If so, what type?

No

Are you very sensitive to touch / pressure in any areas?

What type of pressure do you like?

What is your goal in the session today?

Your answers to these questions will be discussed with you prior to your sesson. Thank you.

Please Take a moment to carefully read the following information and sign where indicated

I understand that the massage I recieve is provided for the basic purpose of relaxation, stress reduction, and relief of muscular tension. If I experience any pain or discomofrt 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 should not be considered as a substitue for medical examination, diagnosis, or treatment and that I should see a physcician, chiropractor, or other qualified medical specialist for any medical or physical ailment that I am aware of.

I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnosis, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session(s) given should be considered as such.

Because massage is contraindicated under certain medical conditions, I affirm that I have state 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 not be liability on the practioner's part should I forget to do so.

Signed: _____ Date: _____

Signature of guardian: _____ Date: _____