Client Information

Escape Life's Velocity
Ashley Molnar, L.M.T.
P.O. Box 90
Pluckemin, N.J. 07978
(908)-616-1770

Name _____ Phone (_____) _____ Date _____

Address_____City_____ State_____ Zip_____

D.O.B: _____/_____/_____ E-mail:_____

Referred by: _____ Phone (_____) _____

In case of emergency:_____ Phone (_____) _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

If you answer "yes" to any of the following questions, please explain as clearly as possible in lines provided below.

☐ Yes ☐ No	Do you frequently suffer from stress?	☐ Yes ☐ No	Do you have any joint or muscle pain / stiffness?
☐ Yes ☐ No	Do you experience frequent headaches?	☐ Yes ☐ No	Do you have numbness or stabbing pains?
☐ Yes ☐ No	Do you have diabetes?	☐ Yes ☐ No	Are you sensitive to touch or pressure in any area?
☐ Yes ☐ No	Do you have varicose veins?	☐ Yes ☐ No	Do you suffer from arthritis?
☐ Yes ☐ No	Are you pregnant?	☐ Yes ☐ No	Do you bruise easily?
☐ Yes ☐ No	Are you wearing contact lenses or dentures?	☐ Yes ☐ No	Any broken bones in the past two years?
☐ Yes ☐ No	Do you have any contagious diseases?	☐ Yes ☐ No	Any injuries in the past two years?
☐ Yes ☐ No	Do you suffer from joint swelling?	☐ Yes ☐ No	Do you suffer from back pain or disk herniation?
☐ Yes ☐ No	Do you have low / high blood pressure?	☐ Yes ☐ No	Do you have osteoporosis?
☐ Yes ☐ No	And/or take medication to manage blood pressure?	☐ Yes ☐ No	Do you have any allergies or sensitivities (i.e. nuts, iodine, shellfish, flowers, scents)?
☐ Yes ☐ No	Do you have a thyroid/endocrine condition?		
☐ Yes ☐ No	Do you have cardiac or circulatory problems?	☐ Yes ☐ No	Have you ever had surgery?
☐ Yes ☐ No	Do you suffer from epilepsy or seizures?	☐ Yes ☐ No	Other medical condition, or are you taking any medications?
Handed?:	☐ Right ☐ Left		

Comments _____

_____

_____

Have you ever experienced a professional massage or bodywork session? ☐ Yes ☐ No How recently?_____
What are your goals for today's treatment? _____
What kind of pressure do you prefer? ☐ light ☐ medium ☐ firm

I understand that the massage/bodywork/spa treatment I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain/ discomfort during this session, I will immediately inform the practitioner so that the treatment, 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 Signature_____Date_____

Practitioner Signature_____Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize ____Ashley Molnar, L.M.T.____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____Date_____