



ADVANCED INTEGRATED HEALTHCARE LLC
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 advancemyhealth.com
An Integrated Approach to Wellness

MESSAGE CLIENT INFORMATION

PERSONAL INFORMATION

Name:	Sex: M F	Date of Birth:	Date:
Address:	City:	State/Zip:	
Home Phone:	Work Phone:	Cell Phone:	
Email:	Age:	Occupation:	

Who referred you to our office? _____
 Please provide an emergency contact and phone number. _____

GENERAL AND MEDICAL INFORMATION

Have you ever had a professional massage? Yes No If yes, how often? _____
 Are you pregnant? Yes No If yes, what is your due date? _____
 Do you wear contact lenses? Yes No
 Do you have high blood pressure? Yes No If yes, is it under control? _____
 Do you suffer from seizure disorders or epilepsy? Yes No
 Are you diabetic? Yes No If yes, is your diabetes under control? _____
 Have you broken any bones in the past two years? Yes No If yes, which? _____
 Do you have cardiac or circulatory problems? Yes No If yes, please explain. _____

Have you ever had surgery? Yes No If yes, please explain. _____

Please describe any other medical conditions or injuries. _____

Are you currently taking any medications? Yes No If yes, what for? _____

Do you suffer from back pain? upper, mid, lower back? Yes No _____

Do you experience headaches? Yes No _____

Do you have tension or soreness in a specific area? Yes No If yes, where? _____

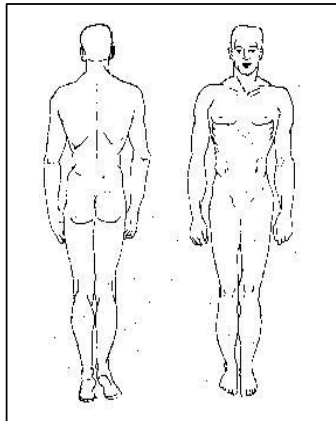
What activities, movements, positions make this worse? _____

What activities, movements, positions make this better? _____

Are you sensitive to touch/pressure in any area? (ticklish?) Yes No

Are you allergic or sensitive to any oils (essential oils, nut oils, scents)? Yes No If yes, please list. _____

Please circle the areas that bother you.



Please provide additional information about your health to assist your therapist in providing a beneficial and therapeutic massage (previous injuries, goals for massage, etc.).

MESSAGE CLIENT WAIVER

Please take a moment to *read and initial* the following information:

___I understand that massage therapy is provided for stress and/or inflammation reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.

___If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.

___I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

___I affirm that I have notified my therapist of all known medical conditions and injuries.

___I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.

___I understand that massage is entirely therapeutic and non-sexual in nature.

___By signing this release, I hereby give consent to massage therapy services and waive and release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.

___I have received the privacy policy statement, and have read and agree to the policies therein.

CLIENT NAME: _____ **DATE:** _____

CLIENT SIGNATURE: _____

INFORMATION AND SUGGESTIONS

- Prior to your massage, please remove contact lenses and all jewelry. Pull long hair back with a clip or band.
- Please undress to your level of comfort. You will be covered with a top sheet throughout your session. This is your massage and you should be as comfortable as possible.
- Feel free to ask your therapist any questions before, during, or after the session. Your therapist is a highly trained professional and will be happy to make you feel informed and comfortable.