Sunrise Healing Arts LLC

CLIENT INFORMATION FORM

www.sunrisehealingarts.com

Name: _____ **Date:** _____

Address: _____

Phone: _____ **Cell:** _____ **E-mail:** _____

Birth Date: _____

Occupation: _____

Referred by: _____

Have you ever had a massage or bodywork session? ☐Yes ☐No
If yes, how recently? _____

Allergies: _____

If you answer "yes" to any of the following questions, please explain as clearly as possible in the "comments" column.

☐Yes	☐No	Do you frequently suffer from stress?
☐Yes	☐No	Do you have diabetes?
☐Yes	☐No	Do you experience frequent headaches?
☐Yes	☐No	Are you pregnant?
☐Yes	☐No	Do you suffer from back pain?
☐Yes	☐No	Do you have cardiac or circulatory problems?
☐Yes	☐No	Do you have arthritis?
☐Yes	☐No	Are you wearing contact lenses?
☐Yes	☐No	Do you have high blood pressure?
☐Yes	☐No	If "yes" to previous question, are you taking medication?
☐Yes	☐No	Do you suffer from epilepsy or have seizures?
☐Yes	☐No	Do you have varicose veins?
☐Yes	☐No	Have you had surgery?
☐Yes	☐No	Do you have any contagious disease?
☐Yes	☐No	Do you have osteoporosis?
☐Yes	☐No	Do you bruise easily?

☐Yes	☐No	Have you had any broken bones in the last 2 years?
☐ Yes	☐No	Have you been in an accident or suffered any injury in the past 2 years?
☐ Yes	☐No	Do you have areas of numbness or stabbing pains?
☐ Yes	☐No	Do you have any other medical conditions I should be aware of?

Comments:_____

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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.

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and or strokes maybe 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 ailments that I am aware of. 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 forget to do so. It is also understood 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:** _____

Consent to Treatment of Minor: By my signature below, I hereby authorize Sunrise Healing Arts LLC to administer massage, bodywork or somatic therapy techniques to my child or dependent, as they deem necessary.

Signature of Parent of Guardian_____ **Date:** _____