Beach Haven Therapy

CLIENT CONSULTATION FORM

Name ______________________________ Email ________________

Address ______________________________ Emergency contact ______________ Phone ___________

Phone ________________ Therapist ______________________________

D.O.B. ________________

**Please answer the questions below.

How did you learn about us? ______________________________

Have you received massage therapy or bodywork before? ☐ Yes ☐ No

Are you on any medication? ☐ Yes ☐ No If yes, which ones ______________________________

Do you exercise? ☐ Yes ☐ No If yes, how many times per week ? _____ How many hours? _____

Treatment, inc additional services: ______________________________

**Please mark any of the following conditions you may currently have.

☐ Neck injury	☐ Alcohol within 24hrs	☐ Recent surgery
☐ Infection	☐ Kidney alignment	☐ Open wounds
☐ Pms	☐ Sports injury	☐ Osteoporosis
☐ Emotional changes	☐ Phlebitis	☐ Chronic pains
☐ Sinus congestion	☐ Bruises	☐ Blood clot
☐ Headaches	☐ High Blood pressure	☐ Fever within 24hrs
☐ Cold virus	☐ Varicose veins	☐ Wear contacts
☐ Flu	☐ Acute pain	☐ Others, please specify
☐ Allergies	☐ Grief process	______________________

I understand that massage therapy is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. The massage therapist does not prescribe medical treatment nor perfom spinal manipulations. I will inform the therapist of my current condition at the time of each visit.

Client Signature ______________________________ Date: ______________________

Therapist Signature ______________________________ Date: ______________________