Medical History

Are you taking any of the following Medications or OTC products?

❑ Pain Relievers ❑ Aspirin ❑ Muscle Relaxers ❑ Stimulants ❑ Insulin ❑ Blood Thinners

❑ Blood Pressure Regulators ❑ Thyroid ❑ Vitamins/Supplements _____

❑ Other (please list) _____

Please review the following medical conditions.
Please indicate your experience with any of these conditions by circling whether you have experienced them in the Past (P) or if you are Currently experiencing them (C).

P or **C**	Allergies/Sensitivities	**P** or **C**	Rashes/Athlete's Foot	**P** or **C**	Skin Conditions/Scratches
P or **C**	Difficulty Sleeping	**P** or **C**	Tension/Stress	**P** or **C**	Fatigue
P or **C**	Digestive Problems	**P** or **C**	Kidney Problems	**P** or **C**	Sinus Problems
P or **C**	Fainting/Seizures/Epilepsy	**P** or **C**	Hepatitis/Liver Issues	**P** or **C**	Anemia
P or **C**	Frequent Neck Pain	**P** or **C**	Muscle/Joint Pain	**P** or **C**	Artificial Joints
P or **C**	Heart Attack/Stroke	**P** or **C**	Heart Surg./Pacemaker	**P** or **C**	Heart Problems
P or **C**	High/Low Blood Pressure	**P** or **C**	High Cholesterol	**P** or **C**	Pregnancy
P or **C**	HIV+/AIDS	**P** or **C**	Surgery of any kind	**P** or **C**	Cancer/Chemotherapy
P or **C**	Lower Back Problems	**P** or **C**	Spinal Column Disorders	**P** or **C**	Sprains/Strains
P or **C**	Lung/Breathing Problems	**P** or **C**	Anxiety/Depression	**P** or **C**	Diabetes
P or **C**	Numbness or Tingling	**P** or **C**	Muscle/Bone Injuries	**P** or **C**	Chronic Pain
P or **C**	Severe/Frequent Headaches	**P** or **C**	TMJ/Jaw Pain	**P** or **C**	Arthritis
P or **C**	Vision Problems/Contacts	**P** or **C**	Hearing Problems	**P** or **C**	Dental Issues/Dentures

Explain any of the areas noted above: _____
_____
_____

Are you allergic or sensitive to any lotions, creams, ointments, essential oils, or to any other topical or scented products? Please Note them here.
_____

Policies & Consent for Treatment

I understand that the massage given to me today by Heaven Sent Massage of Ellijay is for the purpose(s) of stress reduction, pain reduction, relief from muscle tension, increasing circulation, and/or other specific reasons not stated here.

I understand that the massage therapist does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy.

I understand that if I experience any pain or discomfort 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 understand that massage therapy is not a substitute for medical care and that it is recommended I work with a primary caregiver for any condition I may have.

I have stated all my known physical conditions and medications, and I will keep the massage therapist updated on any changes, and I understand that Heaven Sent Massage of Ellijay shall have no liability if I should fail to do so.

I understand that policy requires a payment in full for all services rendered at the time of visit. There is a requirement of 24 hours' notice prior to scheduled appointment time to avoid cancellation fee of $30. I understand my appointment entitles me to a specific time slot. I understand that if I arrive late for my appointment, I will only receive treatment for the remaining time.

Client's Printed Name Client's Signature Date

Heaven Sent Massage of Ellijay

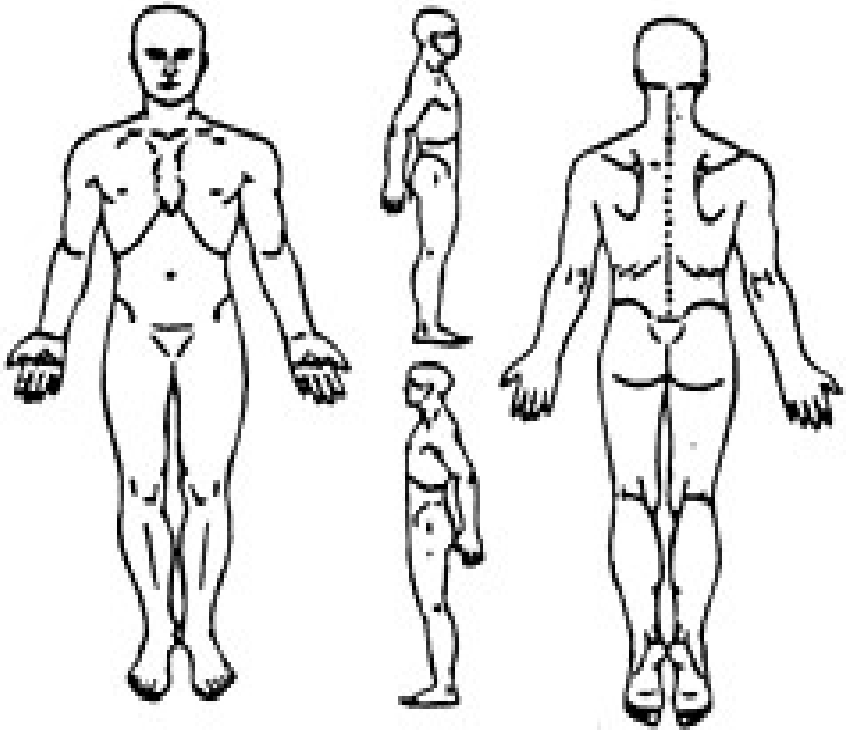
Client Information: Tell Us About You

Name:	
Today's Date: / /	Your Birthday: / / M/F
Address:	City/ST/Zip
Home Phone: ( ) -	Cell Phone: ( ) -
Email: @ .	Would you like to be Opted-In for Appointment Text Reminders? ❑ Yes ❑ No
Occupation:	Work Phone: ( ) -
Do you sit for prolonged hours at a workstation, computer, desk, driving, or at home? ❑ Yes ❑ No	
Do you exercise Regularly? ❑Yes ❑ No	
If so, what types? ❑ Walking ❑ Yoga/Stretching ❑ Strengthening/Weight Bearing ❑ Other(s):	
How did you hear about us? ❑ Flyers ❑ Internet ❑ Friend/Family ❑ Other:	
Referred By:	

Tell me how I can help you today…

What are your goals or expectations regarding massage therapy? (Please check all that apply)
❑ General Relaxation ❑ Stress Reduction ❑ Increased Range of Motion ❑ Reduction in Pain ❑ Assistance with Stretching
❑ General Wellness ❑ Specific Condition Resolution/Management; Please Specify: _____

Are there any areas of your body that are bothering you today? Please indicate on the chart below.
A = Aching Pain, B= Burning Pain, N= Numbness or Tingling, S= Swelling, T= Tightness or Stiffness



Have you ever received Massage or Bodywork before? ❑ YES ❑NO
If Yes, what type of Massage or Bodywork have you experienced? ❑ Relaxation ❑Deep Tissue ❑ Therapeutic
❑Other(s) _____
Please indicate if you prefer ❑ light, ❑ medium, or ❑ firm pressure.

Please Go to Next Page →