Mountain Meadow Massage Therapy. 720-346-3948. www.mountainmeadowmt.com

Client Information

Name _____ Date of Birth _____

Mailing Address _____

City _____ State _____ Zip _____

Phone Number _____ Email _____

Occupation _____

How were you referred to MMMT? _____

In case of an emergency contact _____ Phone _____. (this is someone who can come get you during or after the session if needed.)

Please list any medications you are taking and the reason for taking each of them.

_____

_____

Please list any skin problems you may have.

_____

Have you ever had surgery? Please list dates and reasons for the surgery.

_____

_____

Do you have any current injuries or pain? If so, please describe.

_____

_____

Please list any topical or food allergies _____

Do you have any of the following? Check all that apply.

ADHD		Cancer		Drug or Alcohol Abuse		Kidney Problems	
AIDS/HIV		Carpal Tunnel Syn		Epilepsy		Neck Pain	
Anxiety		Chronic Backaches		Heart Disease		Plantar Warts	
Arthritis		Chronic Headaches		High/Low Blood Pressure		Pregnant or trying	
Asthma		Contagious Disease		Infections		Severe Stress	
Blood Clots		Depression		Insomnia/Sleep Disturbances		Stomach/Digestive Problems	
Bruises		Diabetes		Joint Inflammation		Varicose Veins	

List any physical hobbies that may contribute _____

Do you consider yourself healthy with good diet, exercise, and stress management skills? Yes No

Have you ever had a professional massage before? Yes No

What are your goals for this therapy session? _____

_____

I understand that certain medical conditions or symptoms may be a contraindication for massage therapy. I have stated all my known medical conditions to the best of my knowledge. I agree to keep the massage practitioner updated on any changes in my medical profile, and understand the massage practitioner will not be liable if I fail to do so. I understand that massage therapy is not a substitute for medical or psychological examination, diagnosis, or treatment. Please inform your medical practitioner &/or psycho-therapist of any concerns that arise as a result of the body-work. All recommendations are to be viewed as suggestions.
If I experience any pain or discomfort during the session, I will immediately inform the practitioner that the strokes, pressure, or other negative stimuli should be adjusted to my level of comfort. It is also understood that sexual or suggestive remarks or advances, of any kind, are inappropriate and will result in immediate termination of the session.

Client Signature _____ Date _____

All information is confidential in accordance to HIPAA regulations except where required by law.