CLIENT REGISTRATION FORM

About You

Name		Surname	
Email			
Adress			
Occupation			DOB
Mobile phone			Work phone

Health history

Please mark all conditions that apply

☐	headaches	☐	neck pain	☐	back pain	☐	jaw clenching/ teeth grinding
☐	leg/ knee pain	☐	seizures	☐	bruise easily	☐	high blood pressure
☐	varicose veins	☐	wear contact lenses	☐	diabetes	☐	fybromyalgia
☐	active cancer	☐	numbness/ tingling (if so where?)				

Please list any conditions you have or side-effects you have and/or medications you are taking associated with these conditions

Accidents, injuries and/ or surgeries in the last two years? Please list, including date of occurrence

Are you pregnant or trying to become pregnant?

☐	Yes	☐	No	If yes, how many weeks _____ due date -_____

Postpartum two years or less? ☐ ☐

☐	Yes	☐	No	If yes, birth date _____

Do you have any allergies and/ or skin sensitivities?

☐	Yes	☐	No	If yes, please list :

Our products may contain nut oils. Are you allergic to nut or nut products?

☐	Yes	☐	No	If yes, please list the types of nuts :

Are there any additional medical conditions we should know about?

If you have an issue you do not wish to state on this form, please discuss it with your therapist.

Terms and conditions

By signing bellow, I agree that I have read and understand the following:
I understand that the services offered today are not a substitute for medical care and that prior to my treatment, I have informed my Therapist of all known medical conditions and injuries.
I agree to inform the Therapist of any changes in my health and medical condition during my treatment.
I understand that my treatment is entirely therapeutic and non-sexual in nature.
By signing this release, I hereby waive and release my Therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.

SIGNATURE	DATE	THERAPIST SIGNATURE