OASIS WELLNESS THERAPIES
MASSAGE AND REIKI

Personal Information

Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Occupation: _____

E-Mail: _____ Refereed by: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Massage Experience

Have you ever received a professional massage before? (Please Circle) Yes No

What are your goals for this treatment? _____

Current Health

Are you experiencing any tension, stiffness, discomfort, or pain? (Please Circle) Yes No

If yes, please explain _____

Have you recently had an injury, surgery, or areas of inflammation? (Please Circle) Yes No

If yes, please explain _____

Do you have any allergies to oils, lotions, or ointments? (Please Circle) Yes No

If yes, please explain _____

Please list any medications you are currently taking: _____

_____

Health History

Please check all that apply.

Musculoskeletal
___ Bone or joint disease
___ Tendonitis/Bursitis
___ Arthritis/Gout
___ Jaw Pain (TMJ)
___ Lupus
___ Spinal Problems
___ Migraines/Headaches
___ Osteoporosis

Circulatory
___ Heart Condition
___ Phlebitis/Varicose Veins
___ Blood Clots
___ High/Low Blood Pressure
___ Lymphedema
___ Thrombosis/Embolism

Respiratory
___ Asthma
___ Emphysema
___ Allergies, specify:_____
_____
___ Sinus Problems

Nervous System
___ Shingles
___ Numbness/Tingling
___ Pinched Nerve
___ Chronic Pain
___ Paralysis
___ Multiple Sclerosis
___ Parkinson's Disease

Reproductive
___ Pregnant, weeks _____
___ Menstrual Problems
___ Prostate

Skin
___ Rashes
___ Cosmetic Surgery
___ Athlete's Foot
___ Herpes/Cold Sores

Digestive
___ IBS
___ Bladder/Kidney Ailment
___ Colitis
___ Crohn's Disease
___ Ulcers

Psychological
___ Anxiety/Stress
___ Depression

Other
___ Cancer/Tumors
___ Diabetes
___ Drug/Alcohol/Tobacco
___ Contact Lenses
___ Dentures
___ Hearing Aids

Any other medical condition(s) not listed:
_____
_____

Please explain any of the conditions that you have marked above :
_____
_____
_____

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Client Agreement

I , _____, understand that the session 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 therapist (Jessica MacMillan-Barney, LMT) so that the session may be adjusted to my level of comfort. I further understand that massage therapy 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 ailment of which I am aware.

I understand that massage therapists 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 therapy 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 fail to do so.

I also understand that ANY illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session.

Signature: _____ Date: _____