

Client Information

Name _____ Date _____

Address _____ City, State & Zip _____

Phone _____ (Circle: Cell / Home / Work) Email _____

I prefer to receive appointment reminders via: Text Phone call/Voice mail Email

Birth day _____ / _____ / _____ Occupation _____

Emergency Contact _____ Phone _____

IMPORTANT! PLEASE NOTE:

Stone Therapy Massage is not suitable for everyone. Please review the list of contra- indications below. If any of these conditions apply to you, then you should **NOT** receive Stone Therapy Massage. If you have any doubt whether Stone Therapy Massage is safe for you, please check with your doctor before receiving this modality.

- | | | |
|--|--|---|
| <input type="checkbox"/> Blood clots/prone to clotting | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Lupus | <input type="checkbox"/> Inflamed skin conditions |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epstein Barr | <input type="checkbox"/> Nerve Trauma |
| <input type="checkbox"/> Chemo or radiation treatments | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Depressed immune system | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Open wounds or sores |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heat sensitivity | <input type="checkbox"/> Peripheral vascular disorder |
| <input type="checkbox"/> Recent surgery | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Taking medications that have side effects to heat | |

Current Health Information

Are you generally in good health? Yes No Daily water intake: _____ 16 oz glasses

Activity Level: Exercise: regularly occasionally never
Stretching: regularly occasionally never

List sports/exercises/hobbies you do regularly: _____

Have you had other previous professional massage / bodywork? Yes No

Indicate consumption:

- | | | | | |
|----------|-------------------------------|--------------------------------|-----------------------------------|--------------------------------|
| Caffeine | <input type="checkbox"/> None | <input type="checkbox"/> Light | <input type="checkbox"/> Moderate | <input type="checkbox"/> Heavy |
| Alcohol | <input type="checkbox"/> None | <input type="checkbox"/> Light | <input type="checkbox"/> Moderate | <input type="checkbox"/> Heavy |
| Nicotine | <input type="checkbox"/> None | <input type="checkbox"/> Light | <input type="checkbox"/> Moderate | <input type="checkbox"/> Heavy |

How would you describe your overall level of stress? Low Medium High

Have you had previous professional massage / bodywork? Yes No

Are you currently in any pain? Yes No If yes, is it: Light Moderate Severe

Medications currently taking:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> antibiotics | <input type="checkbox"/> anti-coagulants | <input type="checkbox"/> anti-depressants | <input type="checkbox"/> anti-inflammatory |
| <input type="checkbox"/> anti-diuretic | <input type="checkbox"/> anti-stress | <input type="checkbox"/> beta blocker | <input type="checkbox"/> blood thinner |
| <input type="checkbox"/> bronchial dilator | <input type="checkbox"/> diuretic | <input type="checkbox"/> hormone replacement | <input type="checkbox"/> insulin |
| <input type="checkbox"/> muscle relaxant | <input type="checkbox"/> pain killers | <input type="checkbox"/> ulcer medication | <input type="checkbox"/> vitamins/supplements |
| <input type="checkbox"/> other _____ | | | |

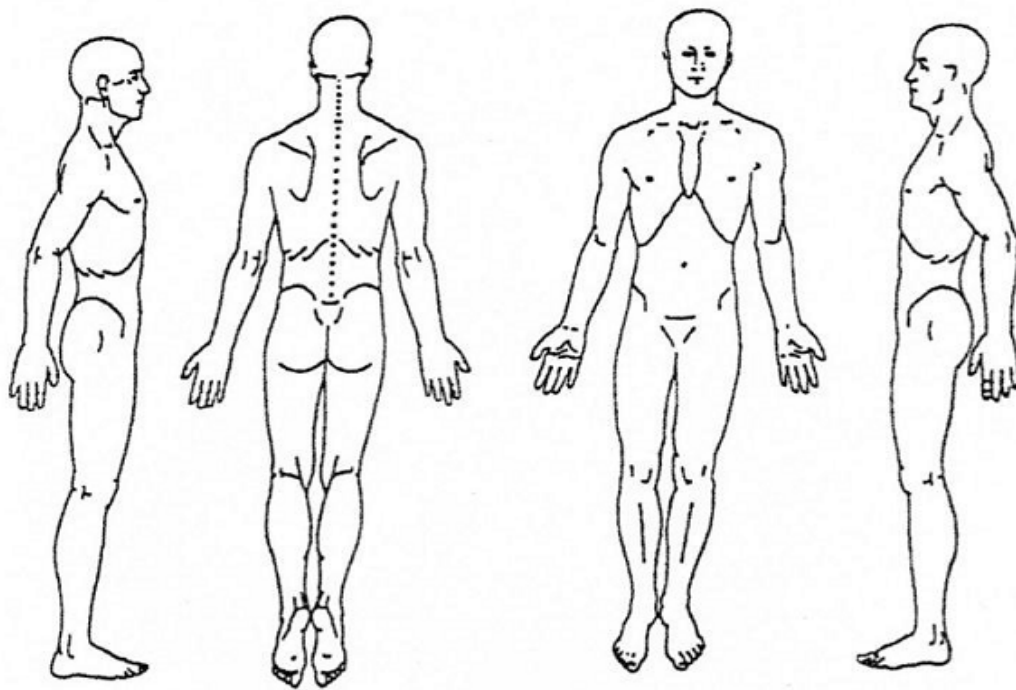
Indicate any that apply. I wear/have:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> contact lenses | <input type="checkbox"/> eyeglasses | <input type="checkbox"/> orthotics | <input type="checkbox"/> hearing aid |
| <input type="checkbox"/> pacemaker | <input type="checkbox"/> dental appliance | <input type="checkbox"/> breast implants | <input type="checkbox"/> hair piece / wig |
| <input type="checkbox"/> allergies | <input type="checkbox"/> undiagnosed lumps | | <input type="checkbox"/> other _____ |

Hot and Cold Stones: The therapist uses volcanic basalt stones heated to 120 degrees; they hold their temperature for a long time, depending on the size of the stone. They are not left resting on your skin unless covered or cool enough to place. Specially designed marble stones are used in conjunction with heated stones to reduce inflammation and to create a dilating and constricting effect in the tissue. This brings about greater relaxation for tight muscles. The cold stones are chilled in an ice water bath. Though it sounds uncomfortable, the hot/cold contrast brings amazing relief to chronic tension. Cold stones will always be followed by hot stones to rewarm the body. However, if you are sensitive to cold, please indicate below that you would prefer not to have cold stone therapy applied.

- No, **DO NOT** include cold stone therapy at this time.

On the figures below, please circle the area(s), if any, that you would like me to particularly address:



Right

Left

A Word About Hydration: The temperature of the treatment may be comparable to sitting in a sauna. It is **very important** that you are well hydrated before and after your session to prevent dizziness and/or nausea. Please drink water before (but not right before) your session. It is recommended that you continue hydrating after you leave.

- I understand I need to be hydrated before and after treatment.

Please read and sign:

I understand that Stone Therapy Massage is for the purpose of stress reduction and/or relief from muscular tension/spasm; and that the therapist does not diagnose illness, disease, or any other physical or mental disorder, or prescribe medical treatment or perform spinal manipulations. Information exchanged during the session is educational in nature and intended to help me become more conscious of my own health status. I have reported all my existing medical conditions and agree to report any changes as they occur. I understand I have the right to refuse treatment at any time during the session. I consent to have Stone Therapy Massage and do not hold the therapist liable for complications that may arise as a result of this treatment.

Please note: If you have a specific medical condition or present specific symptoms, certain massage or bodywork techniques may be contraindicated. A referral from your primary care provider may be required prior to your session. When no referral is provided the therapist reserves the right to refuse treatment.

Client Signature _____ Date _____