Bodywork's THERAPY

First Name:_____ Last Name:_____

Birthday: _____

Mobile:_____

Address:_____

City:_____Postal Code:_____

E-mail: _____

Occupation: _____ Contact: _____

Emergency Contact: _____

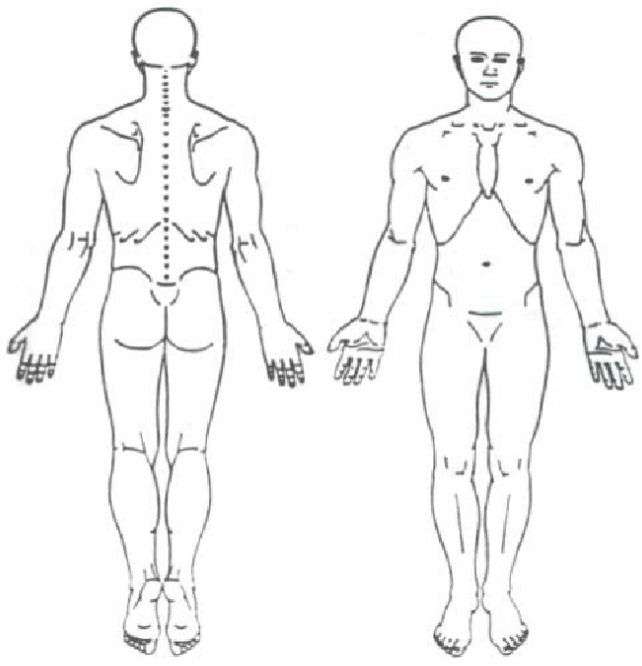
Phone: _____

Referred by:

TREATMENT (Please select one)

- ◉ RELAXATION massage ----------Pressure[**Light**]
- ○ THERAPEUTIC massage ------Pressure[**Medium**]
- ○ DEEP TISSUE massage ----------Pressure[**Firm**]
- ○ SPORT TREATMENT----------Pressure[**Deep**]
- ○ THAI YOGA Stretch ------Pressure[**Firm/Deep**]
- ○ FOOT massage ○ Neck & Shoulder massage

Mark the Area where **You have problems**



Please indicate if you had any of the following or **medication** please let us know

- ☐ TMJ
- ☐ Headaches/Migraine
- ☐ Fibromyalgia
- ☐ Multiple Sclerosis
- ☐ Skin Problem/Bruise
- ☐ High Blood / Low Blood Diabetes
- ☐ Blood Infection/Tooth
- ☐ Kidney Disease
- ☐ Lungs Problem
- ☐ Disease
- ☐ Digestivedisorder
- ☐ Cancer
- ☐ Carpal Tunnel Syndrome
- ☐ Vision Problem/Loss
- ☐ Anxiety
- ☐ Stress
- ☐ Pregnant _____weeks
- ☐ Any_____
- ☐ Any surgery,trauma Yes ☐ [No ☒

Motor Vehicle Accident

WCB CLAIMS:

Any Medication within 24hrs?

Any Allergy?

When is your last massage?

Cancellation Policy

If you are unable to make an appointment, please give *Bodywork's Therapy* **3**Hours Cancellation Notice. You will be responsible for the **Full Amount** of your treatment for failure to do so. We thank you in advance for your cooperation.

Disclaimer and Liability

I _____, understand that the massage I receive is provided for the basic of relaxation and relief of muscular tension. During this session, I will immediately inform the therapist to adjust on my level of comfort.

I further understand that the massage should not be construed as a substitute for medical examination, diagnose or treatment and that I should see a physician or other qualified Medical specialist. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability from any problems arising on the treatment on the therapist's part should I fail to do so.

Client Sign _____Date_____