

~ Divine Lasting Care ~ by Danielle L Carr ~

Client Information

Date / /

Name: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

In Case of Emergency: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Referred by \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Occupation \_\_\_\_\_ Details: \_\_\_\_\_

Type of regular weekly exercise \_\_\_\_\_

Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Chiropractor \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Other \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Previous experience with massage: \_\_\_\_\_

Knowledge of essential oils: \_\_\_\_\_ Are you sensitive to scented oils? Y / N

Any known allergies \_\_\_\_\_

Some medications are contraindications for massage in conjunction with essential oils or massage modalities. Please list current medications including aspirin, ibuprofen, herbs, supplements, etc, as well as any intoxicating substances:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Serious injuries or surgeries? Please include dates:

\_\_\_\_\_  
\_\_\_\_\_

Please mention all physical conditions that apply now.

\_\_\_ headaches

\_\_\_ neck pain

\_\_\_ tight jaw

\_\_\_ grind teeth

\_\_\_ clench teeth

\_\_\_ lower backaches

\_\_\_ leg pain

\_\_\_ Pregnancy \_\_\_\_\_ months

\_\_\_ other:

Current conditions that exist or are causing pain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Describe why you came in for body work/massage: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please indicate desired modalities:

Full Body:    deep pressure            light pressure            Specific Target Area \_\_\_\_\_

OR \_\_\_\_\_

Raindrop Therapy (see additional page)

I have received my copy of Raindrop Technique information and understand the process: \_\_\_\_\_ (initials)

I, \_\_\_\_\_ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension.

\* I will communicate my response to the massage on a 1-10 pain scale for my comfort and safety. Pain or discomfort has no place in a therapeutic massage.

\* I am aware that I have the right to end the session at any point for any reason.

\* Draping will be used during the entire session.

\* I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a qualified medical specialist such as a physician, or chiropractor for any mental or physical ailment that I am aware of.

\* 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 should be construed as such.

\* Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. Since massage should not be received while under the influence of alcohol or other intoxicating drugs, I affirm that I am aware of the adverse reactions that could occur during a massage and take any and all responsibility if I have withheld this information from my therapist.

\* I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

**Cancellation policy:** I will provide 24 hours notice in the event that I cannot make my scheduled appointment. I understand that I will be charged the full amount for my session if I do not show up for my scheduled appointment, or if I do not notify DLC 24 hours beforehand.

Signature of client \_\_\_\_\_ Date \_\_\_\_\_

Signature of Massage Therapist \_\_\_\_\_ Date \_\_\_\_\_

**Consent to treatment of Minor** (under the age of 18): By my signature below, I hereby authorize Danielle L. Carr/Divine Lasting Care to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Name(s) of Child(ren):

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_