Orange Thai Massage

CLIENT HISTORY

Name _____ Email: _____

Address _____ City/State _____ Zip _____

Phone #_____ Occupation _____

Age _____ Height _____ Weight _____ Male Female

Date of Birth _____ How did you hear about us? _____

If you do have pain or injury, please complete the following:

- **List past surgeries, accidents, painful joints and other traumas:**

_____
_____

- **Check the box if you have had any of the following medical conditions?**

____ Diabetes ____ Varicose veins ____ Stroke ____ Arthritis ____ High blood pressure
____Bruise easily ____ Osteoporosis _____Cancer ____ Pregnancy ____ Migraine headache
____ Other: explain _____

- **Are there any other ailments that we should know about**

  _____
  _____

Medical Disclosure: If I experience pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. Because massage, bodywork and somatic therapy may be contraindicated due to certain medical conditions, I affirm that I have informed the therapist of all my known medical conditions and will keep the therapist updated as to any changes in my medical condition. I understand that I am an active participant in my healing and it is my responsibility to provide accurate and timely feedback to my therapist regarding my response to treatment. I understand that I am in full control of my treatment and have the right to halt any technique at any time by asking my therapist to ease up or stop completely, which will be complied with immediately.

I have read, understood, and agreed to the conditions of the HIPAA Notice of Privacy Practices. By signing below, I acknowledge I have read and understand the above, and consent to treatment.

Name:_____Date:_____