

Name:		Date of Birth:	
Address:			
City:	State:	Zip:	Occupation:
Email:	<i>Email is for appointment reminders, special offers & discounts, newsletter and the email address is never shared</i>		
Home phone:	Mobile phone:		
Emergency contact w/ Relationship:	Telephone #:		
Do you exercise ___ No _____ Yes	If Yes, what activities and how often?		
How did you hear about this massage practice?			
Have you received massage before?	Yes	No	
What did you like or dislike about your previous massages?			
Please indicate your preference in pressure.	Deep	Medium	Light
Are you currently under the care of a Primary Care Physician/Health Practioner for a specific condition?			No_____
Yes_____ If yes, please explain:			
What medications are you taking (including over the counter pain relievers)?			
On a scale of 1 to 10 with 1 being the lowest how would you rate the level of stress/tension in your life? _____	What are your specific areas of tension?		
GENERAL SYMPTOMS <i>Please indicate any of the following symptoms at the present time and add any comments to clarify (such as area of the body, condition etc)</i>			
<i>Circle the appropriate response:</i>	Yes	No	Comments
Swelling or tendency to swell	Yes	No	
Pain and or tenderness	Yes	No	
Numbness or tingling	Yes	No	
Infection	Yes	No	

Adrenia Lugo, LMT 130056
 4849 West Lawther Drive
 Dallas, TX 75214, Vista 3rd Floor
 972-755-4259

SPECIFIC MEDICAL CONDITIONS *If you have ever had any of the following conditions, indicate whether it is past or current and add a few details. Please indicate if any conditions are due to an accident.*

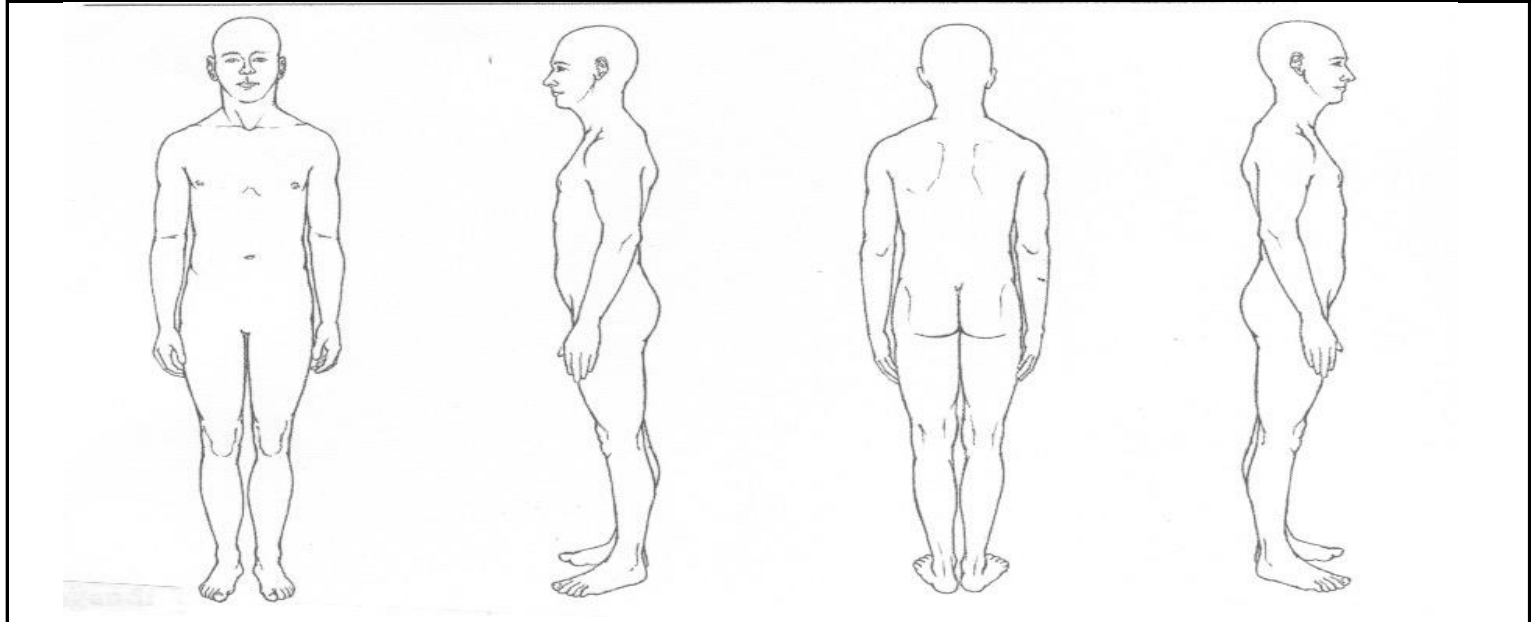
	<i>Circle Response:</i>	<i>Details</i>
Skin Conditions - rashes, itching, infection (including athlete's foot, oral herpes and shingles) and other	Past Current NO	
Allergies (including lotions, oils, nuts, scents, latex)	Past Current NO	
Cancer or Tumors (either benign or malignant)	Past Current NO	
Cardiovascular Conditions (high blood pressure, heart attack, stroke, varicose veins, blood clots, etc.)	Past Current NO	
Respiratory/Lung Conditions (asthma, COPD, etc)	Past Current NO	
Gastrointestinal Conditions	Past Current NO	
Liver or Kidney Conditions	Past Current NO	
Diabetes	Past Current NO	
Arthritis	Past Current NO	
Pregnancy (Indicate if you are trying to get pregnant)	Past Current NO	
Injuries (include approximate date/year)	Past Current NO	
Headaches (tension, migraine, chronic, severity and/or frequency)	Past Current NO	
Surgeries (ie. joint replacements, c-section, orthopedic repairs, abdominal, skin etc., plus year)	Past Current NO	
Neurological/Psychiatric conditions (dementia, MS, Parkinson's, depression, bipolar etc)	Past Current NO	
Other medical conditions not listed above:		
Is there anything else that you feel would be helpful for the practitioner to know?		

The Administrative Rules of the Texas Department of Licensing and Regulation 16 Texas Administrative Code, Chapter 117, Subchapter H, Rule §117.91 states that this initial consultation document is required and that it must indicate the following information:

A statement of the type of massage techniques to be used:	The type of massage that the therapist performs integrates a number of massage methods/techniques including the following: swedish, deep tissue, sports, Thai, and orthopedic massage as well as craniosacral, neuromuscular, trigger point, myofascial, active movement therapy and stretching (including proprioceptor neuromuscular facilitation).
The massage therapist does not perform breast massage.	<i>Clarification: Pectoral muscles are not considered part of breast tissue. Tight pectoral muscles may contribute to back, shoulder and neck pain.</i>
Draping will be used during a massage session.	"Draping" means that your body will be modestly covered by a sheet during the massage.

<p>A statement that if the client is uncomfortable for any reason, the client may ask the therapist to cease the massage and the therapist will do so.</p>	<p>If you are uncomfortable for any reason, you may ask me to stop the massage and I will stop immediately. In addition, as therapist, I also reserve the right to stop the massage session in the event of any sort of abusive behavior from you, the client.</p>
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<p>The parts of the client's body that will be massaged or the areas of the clients body that will be avoided during the session, including indications and contraindications.</p>	<p>On chart below MT will indicate the following: <i>Place an "X" any areas to be avoided</i> <i>Place a CIRCLE on areas that need extra attention</i> <i>Place a "T" where client indicates can be ticklish</i></p>
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I attest to the following:

- ◆ I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications and that spinal manipulations are not part of massage therapy. I understand that massage therapy is not a substitute for medical treatment or medications and that it is recommended that I concurrently work with my Primary Care Provider/Health Practioner for any conditions that I may have.
- ◆ I have read and understood all of the information above.
- ◆ I have stated all conditions that I am aware of and this information is true and accurate to the best of my knowledge.
- ◆ I will inform my health care provider and massage therapist if anything changes in my statuts. I also agree there shall be no liability on the practitioner's part should I neglect to do so.
- ◆ If I experience any pain or discomfort during the massage, I will immediately inform my massage therapist so that the pressure and/or methods can be adjusted to my comfort level.

<p>Client Signature:</p>	<p>Date:</p>
<p>Therapist Signature:</p>	<p>Date:</p>