



BLISSFUL BEING
WELLNESS
MASSAGE. YOGA. HERBALISM

PERSONAL INFORMATION:

Name _____ Date of Birth _____

Email _____ Occupation _____

Address _____ Phone _____

Emergency Contact _____ Relation _____

Emergency Phone _____ If needed, do you consent to a 911 call: YES NO

How did you hear about Blissful Being Wellness? _____

THE FOLLOWING INFORMATION WILL BE USED TO PLAN SAFE AND EFFECTIVE TREATMENTS TAILORED BEST TO MEET YOUR NEEDS. PLEASE ANSWER THE QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

Date of first visit: _____ Have you had a professional massage before? YES NO

If so, how often? _____ What style of massage are you seeking? _____

Do you have any allergies/sensitivities to oils, lotions, skin products, fabrics/materials or essential oils?

YES NO If so please explain _____ Any aversions? _____

Do you have *any* difficulty lying on your back side belly none apply

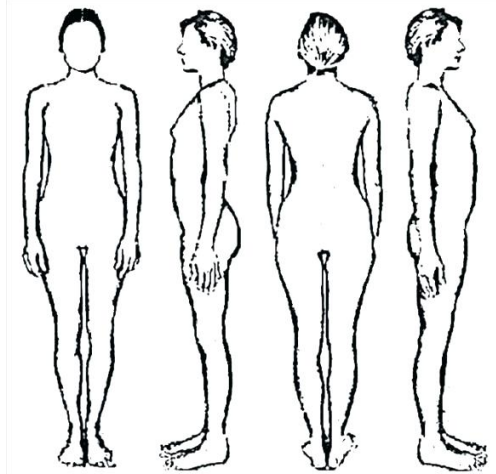
In what position(s) do you sleep? _____ How many hours? _____

What pressure do you prefer? Light Moderate Heavy I don't know

Are there any areas (feet, face, abdomen, etc.) you do *not* want massaged? _____

What are your goals for this treatment? _____

Please **circle** any areas of **chronic** pain/discomfort, **shade** areas of **acute** pain/discomfort:



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MEDICAL INFORMATION:

Are you currently under medical supervision? YES NO Primary Provider _____

Do you visit a chiropractor? YES NO Chiropractor Name _____ How often? _____

Are you taking any medications/supplements? Please list name and use: _____

Do you suffer from chronic pain? Please explain; what makes it better/worse? _____

Do you suffer from chronic stress? Low-grade High-grade How do you notice it manifesting in your life?

Do you sit for long hours at a time (ie: workstation, computer, driving, etc)? YES NO

If yes, please explain: _____

Do you perform repetitive movements in your daily life, work, hobby? YES NO

If yes, please explain: _____

Please check **any and all that apply to you** (past or present) and explain below:

- | | | |
|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart Condition(s) | <input type="checkbox"/> Kidney Dysfunction | <input type="checkbox"/> History of Trauma |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Sprains or Strains | <input type="checkbox"/> Insomnia/Sleep Disorder(s) |
| <input type="checkbox"/> Contagious Condition(s) | <input type="checkbox"/> PTSD | <input type="checkbox"/> Poor Digestion |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Open Wound(s)/Lesion(s) | <input type="checkbox"/> Surgery (last 10yrs) |
| <input type="checkbox"/> Blood-borne Illness(es) | <input type="checkbox"/> Contagious Condition(s) | <input type="checkbox"/> Degenerative Disc Disease |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Tingling/Numbness | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Spinal Condition(s) | <input type="checkbox"/> Chronic Fatigue/ Epstein Barr |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Jaw Pain/Tension (TMJD) |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Plantar's Warts | <input type="checkbox"/> Other Diagnosed Condition(s) |
| <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Gout | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Anxiety/Panic Attack(s) | <input type="checkbox"/> Arthritis (Osteo/Rheumatoid) | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Skin Condition/Irritation | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Prosthetic(s) |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Joint Replacement(s) | <input type="checkbox"/> Blood Clots/ DVT | |

Explain any conditions you have marked above?

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Have you had any orthopedic injuries? YES NO If yes, please explain: _____

Have you had **any** car accidents? YES NO If yes, please explain: _____

Are you currently pregnant? YES NO How far along? _____ Due date _____

Is this your first pregnancy? YES NO If no, which number? _____

Are there any high risk factors or complications with this or previous pregnancies? YES NO

If yes, please explain: _____

Is there anything else about your health history you wish to mention?

INFORMED CONSENT—PLEASE READ:

I, _____, understand that massage/bodywork should not be construed as a substitute for any medical examination, diagnosis or treatment and that I should see a qualified medical specialist if I become aware of that need. I understand that massage/bodywork practitioners 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 given should be construed as such. I affirm that I have stated all my known medical conditions and answered all questions honestly.

I agree to keep the practitioner updated as to *any* changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so and release Blissful Being Wellness, LLC and Alix Marmulstein from any and all liability to me. I understand that any illicit or sexually suggestive remarks, actions, or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. I agree to provide my email address to be used for appointment reminders, treatment plan support, and the Blissful Being Wellness newsletter/events.

Furthermore, I accept the Informed Consent- Policies and Agreements as stated on the Blissful Being Wellness website and understand that should I desire a copy of the document, that it is available to me. I agree to complete payment at time of services, and that any outstanding payments incurred via insurance billing or otherwise are to be paid within two (2) months of first date of service, otherwise I shall be charged late fees associated with outstanding invoices and possibly legal action may follow. If so, I will be responsible for all reasonable costs associated with collection of such fees.

_____ *Initial* ****Cancellation Policy:** In the event of a need to reschedule, *you must notify me within 24 hours of your appointment time otherwise you will be **charged in full** for the appointment.*

Signature of client: _____ Date: _____

Signature of Massage Therapist: _____ Date: _____