CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

Medical Background	
1. Is this your first professional massage? _____ Yes _____No	**10.** Area(s) you would like your therapist to **avoid**: _____
2. If no, how frequently do you get a massage? _____	**11.** Area(s) you would like your therapist to **focus** on: _____
3. What do you hope to accomplish from today's massage? _____	**12.** Pressure Preferred: (Circle one) Light Medium Firm
4. Are you aware of any tension holding spots in your body? _____ Yes _____No If yes, where: _____	**13.** 1-5 with 5 being the most, what is your pain level today? _____
5. Do you have any sensitivity to heat or cold? ____Yes ____No	**14.** 1-5 with 5 being the most, what is your stress level today? _____
6. Do you have any allergies or sensitivity to smells, oils, lotions, or ointments? ____Yes ____No	**15.** Are you Pregnant? ____Yes ____No If yes, How many months? _____
7. Do you have any skin conditions or rashes? ____Yes ____No	**16.** Do you have any difficulty lying on your front, back or side? ____Yes ____No
8. Any recent surgeries or broken bones? _____ Yes _____No If yes, what kind or where: _____	**17.** Do you see a chiropractor? ____Yes ____No
9. Do you have any chronic, ongoing pain that you deal with on a regular basis? ____Yes ____No	**18.** Do you wear contact lenses? ____Yes ____No

I, the undersigned patient, understand, acknowledge and agree that: (i) I am aware the facilities and services offered by Somatic Massage Therapy, P.C. involves risk. (ii) I have provided all relevant information regarding my current health status. (iii) I am seeking the Spa/Medical Massage services at my own free will; and (iv) I assume all risk associated therewith. On behalf of myself and my heirs I hereby release and discharge Somatic Massage Therapy, P.C. (the "Owner") and all of their affiliates, employees, contractors, directors, officers, agents, landlords, representatives, successors and assigns of the owner from any and all claims or causes of actions arising out of or relating to spa services. Including but not limited to, those resulting from bodily injury, theft, loss of, or damage to property of mine unless due to the gross negligence of willful misconduct of Somatic Massage Therapy, P.C., its owner or employees/contractors.

I, further, fully understand, acknowledge and agree all spa services are provided exclusive as a convenience to me by Somatic Massage Therapy, P.C. and I accept the service(s) at my own risk and expense without liability or responsibility to the Spa or its affiliates.

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hours' notice (medical emergencies excluded) will be charged 50% and complete NO-SHOW will be charged 100%.

Signature: _____ **Date:** _____