

1101 Cardenas Dr NE, St#105, Abq, NM bluepearlmedicalmassage@gmail.com
(505)205-3618

Name: _____ Date: _____

Address: _____ (city/state) _____ (zipcode) _____

Birth Date: _____ Phone: _____ Cell Phone _____

Email: _____ would you like text _____ or email _____ reminders.

Describe job: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

Health Care Provider: _____ Phone: _____

Check Yes only and please explain if needed. Use back of form if you need more room

____ Are you under stress? What is it from? _____

____ Do you have diabetes? _____ Do you bruise easily? _____ Do you wear contacts? _____

____ Do you get Headaches? Where? _____ How often _____

____ Are you pregnant? Due date _____

____ Do you have high blood pressure? Is it controlled? ___yes ___no

____ Do you have any scars? Where _____ How new _____

____ Do you have arthritis? Where _____

____ Do you have back or neck pain? Where _____ how often _____

____ Do you have swelling in joint/s? Where _____ how often _____

____ Do you have varicose veins? Where _____

____ Do you have any inflammation? Where _____ How long have you had it _____

____ Do you have a contagious disease? ___ Do you have any allergies? _____

____ Have you ever had surgery? Where on body _____ When _____

____ Do you have osteoporosis? _____

____ Are you currently taking any medication that would interfere with your sensitivity to pressure or pain?

____ Are you sensitive to touch/pressure in any area? If yes where _____

____ Are there any other medical problems or pain I should be aware of?

If yes, please explain _____

____ Have you had a recent accident? Date _____ where _____

____ What hurts _____

____ Car accident/ _____ work related? Has your superior been notified? _____ Claim # _____

____ Do you have an attorney? Name _____ phone _____

____ Are you seeing any other health care provider/s for this accident? Name _____

____ When was your last massage and how often? _____

*Reason for being here today _____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation, stress reduction, and relief of muscular tension and pain. If I experience any pain or discomfort during this session, I will immediately inform you so that the pressure and/ or strokes may be adjusted to my level of comfort.

I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. Nothing said in the course of the session(s) given should be construed as such.

Because massage/ bodywork should not be done under certain medical conditions, 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 forget to do so.

It is also understood that any illicit or sexually suggestive remarks or advances made will result in immediate termination of the session.

24-hour notice to cancel an appointment is required. If 24 hour is not given, you will be charged for it, if it has not filled.

Is there a health care provider you would like me to update with progress reports Yes _____ No _____

*Health Care provider _____ Phone# _____

Clients Signature: _____ **Date:** _____

Consent to treat a minor: By my signature below, I hereby authorize Liz Blasingame to administer massage, bodywork, or somatic therapy techniques to my child/dependent as deemed necessary.

Signature of parent/ guardian _____ Date: _____