Client Information and Informed Consent Sheet

In order to serve you better and make the most or your session, please fill this form out PRIOR to attending your session. Thank you!

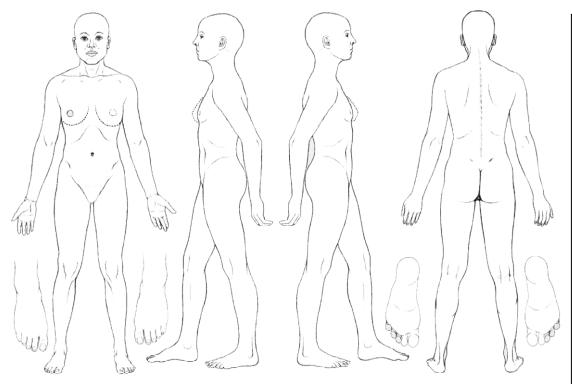


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PLEASE PRINT

DATE:					
Whom may we thank for referring you?					
SECTION 1: CLIENT INFO					
NAME		DOB			/
ADDRESS	CITY		STATE _		_ZIP
PHONE ☐ mobile ☐ home	EMERGENC	CY CONTAC	Т		
EMAIL □ DO NOT ADD ME TO EMAIL/TEXT LIST	Υοι	ı will be adde	d to the Ta	oMas	ssage business list
Height:Weight:					
Occupation?	Married?/0	Children?_			
Sports? Exercise? Hobbies? Activities?					
Medications?					
SECTION 2: PRESENT CONDITION Reason for seeking therapeutic massage?					
If this condition is a result of trauma, accident of one (include date of injury if applicable):					
How long have you had this condition?Other health services sought for this condition?					
When is this condition most problematic for you? What makes the condition better? What makes the condition worse?					



Rate pain on a scale of 0= no pain, 10= severe INDICATE WITH AN "X" where you feel discomfort. INDICATE WITH A ©SMILEY FACE© where massage feels good for you.

Preferred pressure/techniques?:	light	medium	deep	very deep
				_

SECTION 3:

Cancer Diabetes

OTHER CONDITIONS

(CIRCLE applicable and/or please list an "H" for History of condition in family

Pregnant/trying to conceive?

Heart Disease Stroke/Aneurysm High Blood Pressure Medications Transmittable Diseases **Contact Allergies** Surgeries Physical Trauma **Emotional Trauma** Osteoporosis Fibromyalgia Muscle Pains Osteoarthritis Rheumatoid arthritis Anemia Herniated Disk Sciatica Dizziness / fainting Low blood pressure Carpal Tunnel Syn. Thoracic Outlet Syn. Numbness / tingling **Chest Pain Heart Palpitations** Varicose Veins Embolism / thrombus Atherosclerosis Psoriasis / Eczema Rashes Swollen hands / feet Shingles Asthma Smoker / Emphysema Difficulty breathing Sprains / strains Other joint/bone problem Lupus Lyme Disease

		NAME
SECTION 4: YOUR AGREEMENT WITH TAOM	ASSAGE	
	gned for persons who ha re best suited for two-for a therapeutic level that v higher level than that of	ve a firm diagnosis of chronic low back pain. Clients
Due to the serious nature of this technique, we woul soreness, skin irritations, marks, headaches, sinus co hold the modality, massage therapist or the company	ongestion, bruises or any	
Due to the compressive nature of AOBT the following	g conditions are contrain	dicated:
 pregnant or trying to get pregnant 	varicose veins	•acute back pain
osteoporosisrecent eye surgery (within 72 hours)	heart conditionscancer	•breast implants within 9 months
The Ashi DOs & DONTs following an AOBT session hat take proper care of myself following this session as re		to me and I understand that it is my responsibility to CLIENT INITIALS
FLOAT: I attest that I am free of infectious skin disease restricted environmental stimulation therapy, I am n		
	stitute for medical examinate. Because a massage	· · · · · · · · · · · · · · · · · · ·
I understand and accept that I may experience bruisi	ing, stiffness and/or sore	ness following receiving services from TaoMassage.
I understand that if I have indicated that I weigh 350 liable for any equipment failure.	lbs of more, I will not ho	ld the modality, massage therapist or the company
I understand and have read the TaoMassage office p I agree to give 24 hours notice of cancellation of app session. Cases of extreme emergency are considered	ointment. If less than 24	
I understand that any illicit or sexually aggressive rentermination of the session, and I will be liable for pay		
FOR YOUR INFORMATION: The following sometimes occur to express what it needs to: need to move or change posit feelings and/or expression, movement of intestinal gas, fall have carefully read and understand fully and accurately.	ions, sighing, yawning, char lling asleep, memories, nee	nge in breathing, stomach gurgling, energy shifts emotional ding to urinate
CLIENT CICNATURE		DATE
CLIENT SIGNATURE		DATE