



WELCOME TO TURNING POINT

Date: _____

Name: _____ Date of Birth: ___/___/___ Sex: Male Female
 Referred By: _____ Email Address: _____
 Street Address: _____ City: _____ State: _____ Zip: _____
 Phone _____ Type (H M W) Emergency Contact: _____ Phone _____

Have you ever received a professional massage? **YES NO** Do you wear contact lenses? **YES NO**

What do you expect from this massage? (Check all that apply)

- Relief from overworked muscles
- Relief from tension and stress
- Assistance in recovery from strenuous activities

Are you currently in Pain? **YES NO** Where: _____

Is your pain a result of a recent trauma or injury? **YES NO** If yes, please describe: _____

Within the last 3 years have you:

- Had an operation/ surgery? Explain: _____
- Been in a car accident? **YES NO**
- Had any broken bones? Explain: _____

Have you ever had any of the following? (Please circle all that apply)

High/Low Blood Pressure	Arthritis	Sports Injury	Broken/ fractured bones
HIV	Blood clots	Allergies to massage oils	Tendonitis
Other Allergies/ Sensitivities	Neck / Shoulder / Arm Pain	Rashes or skin conditions	Epilepsy
Anxiety/ Stress Related Conditions	Cancer	Diabetes	Heart Condition / Disease

What types of medications are you currently taking?

- Blood Thinners
- Pain Relief
- Other; Please describe _____
- Steroids
- Anti- Viral

Are you under medical care or supervision for any condition? **YES NO**

Has your doctor prescribed massage therapy for health reasons? **YES NO**

Do you have any other medical conditions that have not been mentioned above? If yes, please explain: _____

FEMALES ONLY:

1. Are you currently pregnant **YES NO**
2. Do you have breast lumps? **YES NO**

LIABILITY WAIVER:

I understand that massage therapists do not diagnose illness, disease or any other type of mental disorder. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor does he/she perform any spinal manipulations. It has been made very clear to me that any treatment given here is not a substitute for medical examination, diagnosis and/or treatment and that it is recommended that I see a physician for any physical conditions, I have stated all I know medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Signature Date