

# LIGHTWAY HEALING THERAPEUTIC MASSAGE

## CONFIDENTIAL CLIENT HISTORY FORM

Dear Client,

Thank you for your interest in **Lightway Healing Therapeutic Massage** to assist you in your wellness needs! To better serve you, I have created a Client History Form for you to complete. Please answer each question honestly and completely! If we haven't done so already, you and I will do a brief assessment to help me get a better idea of your individual needs. Please take your time and patiently complete this form. It's all about you! I am so grateful to serve you! God Bless!

**Sincerely,**

**Your Massage Therapist,**

*Stacy Viney-Broussard* 😊

CONFIDENTIAL CLIENT HISTORY FORM

**(Please print legibly)**

NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

EMAIL: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

WHO MAY WE CALL IN CASE OF AN EMERGENCY? \_\_\_\_\_

RELATIONSHIP TO YOU? \_\_\_\_\_ PHONE: \_\_\_\_\_

YOUR AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  MALE  FEMALE

**IS THIS YOUR FIRST PROFESSIONAL MASSAGE?** YES or NO

*\*Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to treatment being provided.\**

**Circle all the following that apply to you:**

HIGH BLOOD PRESSURE	SEVERE LACERATIONS	PHLEBITIS	FIBROMYALGIA	INFLAMMATORY SKIN CONDITION
VARICOSE VEINS	SPASTIC PARALYSIS	ARTHRITIS	LUPUS / RA / MS	OPEN WOUNDS / OOZING BUMPS
HEMATOMAS	WHIPLASH	AIDS/HIV	LOW BACK PAIN	SUBSTANCE ABUSE
HEART PROBLEMS	FRACTURES	INSOMNIA	TMJ	NEUROPATHY
DIABETIES	STIFF NECK	HERPES	THYROID ISSUES	HEAT SENSITIVITY
DIVERTICULTIS	HEADACHES	CANCER	STROKE	EDEMA / LYMPHEDEMA
CONTAGIOUS DISEASES	SKIN DISEASE	OSTEOPOROSIS		
ALLERGIES (including latex)	EPILEPSY / SEIZURES	CARDIAC / CIRCULATORY PROBLEMS		

Other (not stated above); please explain: \_\_\_\_\_

**Y N Are you taking any blood thinner medications?** If yes, please list and what it is used for:

Medication: \_\_\_\_\_ Use: \_\_\_\_\_

**If you circled "ALLERGIES", please list the allergy and its effect on you if exposed to it. (Ex: latex, certain oils). If it is seasonal, please state.**

ALLERGY: \_\_\_\_\_ EFFECT: \_\_\_\_\_

- YES  NO Are you pregnant? How far along are you? \_\_\_\_\_
- YES  NO Do you wear contacts?
- YES  NO Do you wear dentures?
- YES  NO Do you bruise easily?
- YES  NO Are you sensitive to touch or pressure in any area? Please explain: \_\_\_\_\_

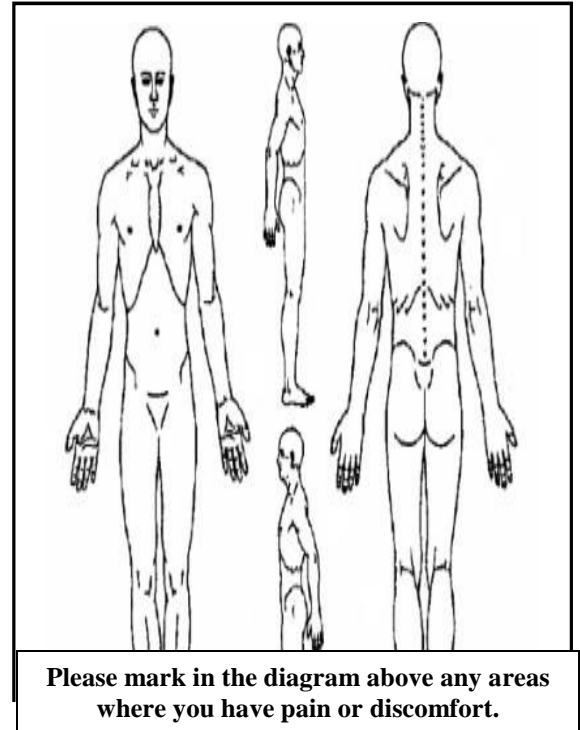
Where do you carry tension? \_\_\_\_\_

Do you suffer from joint  **swelling**  **tension**  **soreness**  
Where? \_\_\_\_\_

In the past two years, have you had any:

**injuries**  **broken bone**  **surgeries**  
Please specify: \_\_\_\_\_

What kind of pressure do you prefer?  **light**  **medium**  **firm**



***Besides manipulation of muscle tissue (massage), I often use other holistic methods of relieving muscle pain and discomfort with essential oils, hot stones, heated towels, medi-cupping, and acupressure bulbs.***

\*Essential Oils offer various types of benefits depending on your need and the oil you use. I often use essential oils to enhance your massage session – oils such as deep blue offer a numbing affect to achy muscles; similar to biofreeze or icy-hot. Lavender offers a relaxing feeling, as well as aids to inflammation. Eucalyptus for sinuses and Peppermint for headaches. These are just a few of the oils I use in my practice. A list of oils can be found below. If you are sensitive to essential oils, please inform me!

\*Hot stones hold heat for a longer period of time. Heat expands muscles, so I often use heated stones to relax and expand muscles before or at the end of your session. Heated towels follow – they are just as relaxing!! Some medical conditions may require hot stones not be used or not be stationary for a longer period of time, therefore modifications will be made in respect to those conditions.

\*Medi-cupping uses plastic cups to suction on the body surface. I may use manual ones or the medi-cupping machine. These cups move over the skin, while gently pulling up on the cups or are parked for a short amount of time to facilitate joint mobilization or soft tissue release. No pain is involved, however skin may turn slightly red for a limited time on the worked area. If you experience discomfort, inform therapist and cups will be removed immediately!

\*Acupressure bulbs have a dull needle at its end to apply direct pressure to hypertensive muscles – it does not go into the skin. The acupressure bulb presses on the trigger point pain and then the muscle tension disperses and alleviates. This too is not painful, but may also cause redness and a circular mark for a limited time around the worked area.

Do you consent to:  **essential oils**  **hot stones**  **heated towels**  **medi-cupping**  **acupressure bulbs?**

Oils I use are by doTERRA: *balance (spruce, ho wood, frankincense, blue tansy, blue chamomile), on guard (wild orange, clove bud, cinnamon, eucalyptus, and rosemary), aroma touch (cypress, peppermint, marjoram, basil, grapefruit, and lavender), deep blue (wintergreen, camphor, peppermint, blue tansy, German chamomile, helichyrsom, and osmanthus) , lavender, peppermint, melaleuca, wild orange, and eucalyptus.*

**Please initial next to each after you read:**

\_\_\_\_\_ I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension.

\_\_\_\_\_ If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

\_\_\_\_\_ I further understand that massage or 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 of which I am aware.

\_\_\_\_\_ 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.

\_\_\_\_\_ Because massage/bodywork should not be performed 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 should be no liability on the practitioner's part should I fail to do so.

\_\_\_\_\_ I also understand that any illicit or sexually suggestive remarks 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 have read, received a copy of, and agree to the Policies and Procedures of Lightway Healing Therapeutic Massage, LLC., including having my credit/debit card on file and used for a small service charge for late cancellations and full service charge for same day cancellations and no shows.

**Client Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Therapist Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Consent to Treatment of Minor:** By my signature below, I hereby authorize \_\_\_\_\_ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian \_\_\_\_\_ **Date** \_\_\_\_\_