Sherri Ireland Armas
MY MASSAGE THERAPIST

Date: Date of Birth:
Name: Occupation:
Address: Phone:
City, State, ZIP: Email:

 What type of health care are you receiving? *(List:)*
 Check as relevant below: *(This information is strictly confidential and may be very important to your therapy)*

Pregnancy	High Blood Pressure	Diabetes
Back/Neck Injuries	Inflammation	Dislocations/Pulled Muscles
Fractures/Bone Injury	Bruise Easily	Arthritis
Heart Problems	Skin Problems	Asthma/Allergies
Recent Surgery	Fibromyalgia	Varicose Veins
Headaches	Numbness/Tingling	Tumors/Blood Clots
Stroke	Cancer	Other

 Expectations of this session:
 Special preference concerning this massage:
 Please list surgeries & years of past surgeries, broken bones, major accidents or serious injuries:
 Physical Activity/Exercise:
 Previous massage/bodywork experience: never occasionally often

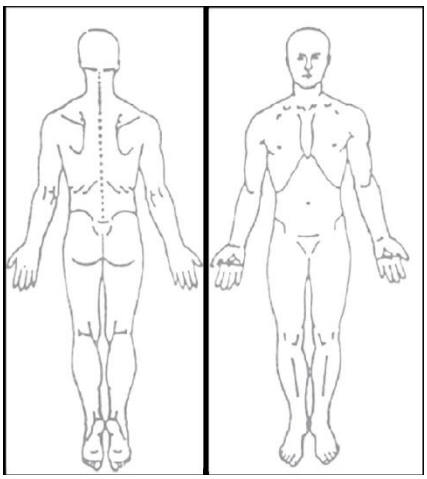
I may itemize here any areas of my body which I wish to be avoided , and these will be avoided (itemize here if relevant:); if I am uncomfortable for any reason I may request the therapist to end the session, and the session will be ended.

 EMERGENCY CONTACT / PHONE NUMBER:

I understand that feedback is essential during massage. It is the client's responsibility to discuss all physical conditions & to inform therapist of any changes after initial session. I understand that massage therapy is for relaxation and stress reduction, it involves neither diagnosis nor treatment of any condition, and is not a substitute for medical care; this session will consist of Swedish massage, Circulatory Sports Massage, Deep Massage; draping will be used at all times (unless client specifically requests otherwise and initials this form to release LMT from liability of such); I agree to hold harmless Sherri Ireland Armas, My Massage Therapist d.b.a., and/or any individual providing therapy or service(s) to me, and the institution where the therapy and/or services are provided, of any responsibility.

Client Signature: Therapist Signature:

If Client is under 18 years of age, parent must sign. As parent or guardian of the above named minor, I hereby consent to said minor's therapeutic massage from Tranquility Time Massage Therapy and have read and agree to the above.
Parent's Signature:
_____



Male / Female

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Confidential Pre-Natal Assessment Form

Name: Delivery Date: Birth date:
Address:
City: State: Zip: Email:
Phone: Occupation:
OB/GYN: Phone: Midwife/Doula: Phone:
Emergency Contact: Phone:

How have you felt during this pregnancy? *Excellent Good Fair Uneasy Sick most of the time*
Conditions related to pregnancy:

Twins	*Previous miscarriage*	*Toxemia*	*Morning Sickness*
Decreased Fetal Movement	*Sensitive to odors*	*Referral from physician*	*Other*

Complications or risks? If so, explain:
Other medical conditions:

Why are you seeking treatment today?
Comments:

Client Signature: Date: