OCEAN
INTEGRATED WELLNESS CENTER
864 Rt 37 West
Toms River, NJ 08755
P. 732-503-4079 F. 732-503-4127

CLIENT INFORMATION FOR MASSAGE

NAME:_____ DOB: _____ Phone: ( )_____

Occupation:_____

Address:_____ City:_____ State:_____ Zip:_____

In Case of Emergency Please Contact:_____ Phone: ( )_____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition(s) or specific symptom(s), massage may be contraindicated. A referral from your primary care provider may be required prior to service being provided (i.e. diabetes, cancer, hypertension, etc.)

___Yes___No Have you ever experienced a professional massage? How recently?_____
___Yes___No Do you frequently suffer from stress? Do you suffer from osteoporosis? ___Yes___No
___Yes___No Do you have diabetes? Do you have varicose veins? ___Yes___No
___Yes___No Have you had any broken bones in the past 2 years? If so, where?_____
___Yes___No Do you suffer from joint swelling? Do you suffer from allergies? ___Yes___No
___Yes___No Do you suffer from arthritis? If so, where?_____
___Yes___No Do you suffer from seizures or epilepsy? Do you suffer from back pain? ___Yes___No
___Yes___No Do you suffer from any contagious disease? Do you bruise easily? ___Yes___No
___Yes___No Do you have high blood pressure? If so, are you taking medication?_____
___Yes___No Have you been in an accident, suffered any injuries, or had surgery in the past 2 years?
___Yes___No Do you have numbness/stabbing pains? If so, where?_____
___Yes___No Do you have soreness/tension? If so, where?_____
___Yes___No Are you sensitive to touch/pressure? If so, where?_____
___Yes___No Do you have cardiac or circulatory problems? Do you suffer from frequent headaches? ___Yes___No
___Yes___No Have you been in an accident/suffered any injuries, in the past 2 years?
If so, please explain _____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. I understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified 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 and physical or mental illness and that nothing said in the course of the session 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist'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 session. I also understand that the effects of alcohol in the body are significantly increased as a result of massage, therefore, massage is contraindicated if I am under the influence of alcohol and the therapist must decline the massage session.

_____ _____
Patient Signature Date

_____
Patient Printed Name

_____ _____
Witness Date