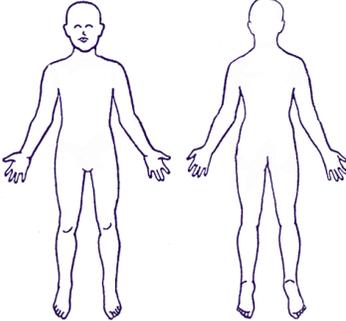


# Marni Matyus, LMT

MT112070

Name		Birth Date	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Occupation
Cell Phone Number	Other Phone		Preferred contact method <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Phone	
Address		City	State	Zip Code
Email				
*Would you like to receive newsletters? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Have You Had A Professional Massage Before? <input type="checkbox"/> Yes <input type="checkbox"/> No      When? _____				
How Did you learn about me?				
<b>Goals for your session:</b> <input type="checkbox"/> Pain Management <input type="checkbox"/> Headache/Migraine <input type="checkbox"/> Neck <input type="checkbox"/> Upper Back <input type="checkbox"/> Lower Back <input type="checkbox"/> Hips <input type="checkbox"/> Knees <input type="checkbox"/> Shoulders <input type="checkbox"/> Other _____  <input type="checkbox"/> TMJ/Intra-Oral <input type="checkbox"/> Cranio-Sacral <input type="checkbox"/> Wellness/Prevention <input type="checkbox"/> Relaxation <input type="checkbox"/> Health/Nutrition Coaching  <input type="checkbox"/> Other: _____		<b>Areas that need extra attention:</b>  <b>Areas to be avoided:</b>   <p>CIRCLE areas to be worked on Mark with a X areas to be avoided</p>		
<b>Medical Conditions:</b> <input type="checkbox"/> Anxiety <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Migraines <input type="checkbox"/> TMJ Disorder <input type="checkbox"/> Neck/Back Pain <input type="checkbox"/> Liver Disease <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Neuropathy <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Contagious Disease _____ <input type="checkbox"/> Skin Conditions _____ <input type="checkbox"/> Skin Rashes _____ <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Spinal Injuries _____  <input type="checkbox"/> Pregnant/Trying to get pregnant/New baby Due Date _____		Other Medical Conditions:  Current Medications & Supplements:  Allergies: <input type="checkbox"/> Fragrance, <input type="checkbox"/> Food, <input type="checkbox"/> Medications (please list)  Injuries or Surgery in the last 12 months:  Anything else the therapist needs to know?		

**- INFORMED CONSENT -**

I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorder, nor do they treat injury or illness, prescribe medical treatment, pharmaceuticals or perform high velocity (chiropractic) adjustments. I understand that if I become uncomfortable for any reason, I may ask the Massage Therapist to cease the massage and the massage session will end.

ANY sexual advance, comment, action, or a client who intentionally exposes themselves will result in IMMEDIATE termination of the session with full payment due and the client will not be allowed to return.

Full body massage may include neck, back, shoulders, hands, arms, legs, feet, gluteus (hips/buttocks), upper chest (not breasts), and scalp. Face and abdomen may be massaged upon request or for specific therapeutic goals. Please identify above any areas that you do not want to be massaged.

Techniques used typically include Swedish, deep tissue, trigger point, myofascial release, stretching, reflexology, cranial sacral, and others that can be discussed with the therapist.

**Clients will be draped at all times. Genitals are never to be exposed or massaged.**

Women's breasts will not be exposed or massaged unless requested for specific medical conditions. A separate consent form is required for breast massage.

**I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.**

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

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

**Consent for treating a minor**

I give permission for my child to receive massage/bodywork by Marni Matyus, LMT.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_