Name:_____ Date: _____

DOB: _____ Email: _____

Cell # _____ Occupation:_____

Address: _____

Emergency Contact #: _____

Name & Relationship: _____

How is your general health? Excellent _____ Good _____ Fair _____ Poor_____

Do you smoke?_____ How often do you use caffeine?_____

How often do you use Alcohol?_____

Referred by: _____ Is this your first Massage? _____

Reason for today's visit? _____

_____

Current medications & the conditions they are treating?

_____ _____

_____ _____

_____ _____

Accidents or surgeries? (including dates): _____

_____

_____

_____

Allergies or hypersensitivities? _____

_____

Do you have now or have you had any of the following:

Asthma ____ Chronic cough ____ Frequent colds ____ Shortness of breath _____
Loss of taste or smell _____ Headaches/migraines _____ Ringing in ears _____
Vision problems _____ Seizures _____Vertigo/dizziness _____ Stroke _____
High blood pressure _____ Heart attack ____ Heart disease ____ Pacemaker_____
Cancer ____ Unexplained weight loss ____ Lyme disease ____ Fibromyalgia _____
Depression _____ Psychiatric disorder_____ Anxiety _____ Jaw pain (TMJ) ____
HIV / AIDS _____ Infectious skin conditions _____ Diabetes _____ Arthritis_____
Digestive conditions _____ Osteoporosis _____ Pins/Plates/ ect _____

Client Agreement & Consent

**I am aware that when I make an appointment, the scheduled time is reserved for me, and should I cancel with less than 24 hours' notice, I am responsible for payment in full. I understand, too, that if I am late for an appointment, Maggie may not be able to give me a full session, though I am responsible for the full charge.

COVID-19 Client Consent:

I understand that COVID-19 is extremely contagious and maybe contracted from various sources. I also understand COVID-19 has a long incubation period during which carriers of the virus may or may not show symptoms and still be contagious.

I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented. However, because this work involves close physical proximity over an extended period of time in a closed space, there may be an elevated risk of disease transmission, including COVID-19. I acknowledge by signing this form I am aware of the risks involved and I give consent to receive Massage Therapy from **Maggie Wissert** on this date and all future massage sessions.

Signature: _____ Date: _____