Massage Client Information and Consultation Form

Name: _____ Date: _____
Last First MI MM/DD/YY

Address: _____
House No Street City State Postcode

Home Phone: _____Work Phone: _____ email: _____

Date of Birth: _____Emergency Contact: _____

Occupation: _____

This Appointment is for Aromatouch: _____

Have you had an Aromatouch before? YES NO If "yes, how long ago? _____

List Current Medications: _____

List any Allergies: _____

Place a check mark next to any of the following that apply:

_____Frequent Headaches

_____Arthritis

_____Varicose Veins

_____Osteoporosis

_____Fibromyalgia / Chronic Fatigue

_____Chronic Back / Neck Pain

_____Blood Clots / Phlebitis

_____Cancer (currently or within past 12 months)

_____Injuries within past 12 months

_____Surgeries within past 12 months

_____Any Skin rash or condition

_____Diabetes

_____Pregnant (Due Date:_____)

_____High Blood Pressure

_____Any Contagious Disease / Illness

_____Allergies (Skin, Drug, Other)

_____Scoliosis

_____Inflammation / Swelling

_____Cardiac or Circulatory Problems

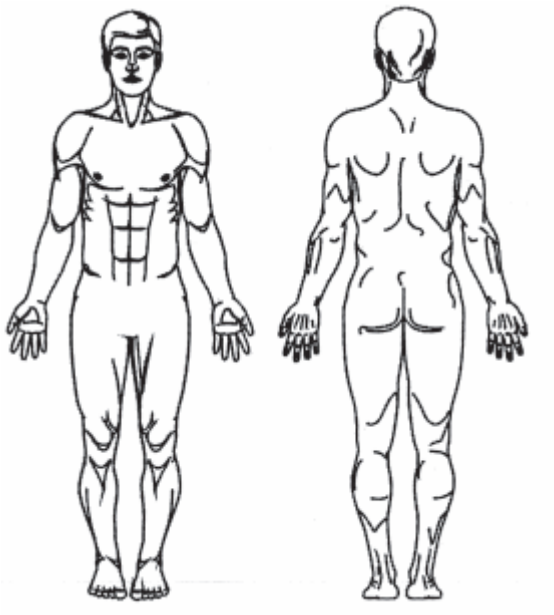
Do you have any other Medical Conditions? _____

What Outcome do you Expect from This Aromatouch Session? _____

_____

The Aromatouch is Light Pressure.

Place an “X” over the areas that you wish to have avoided.



Please Read The Following Information and Sign Where Indicated

I understand that the Aromatouch I receive is provided for the basic purpose of application of essential oils. There are certain medical conditions in which receiving an Aromatouch may not be appropriate. In those cases a referral from a physician may be required prior to services being provided. Aromatouch is not a substitute for medical attention received by a medical specialist. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure/strokes may be adjusted. In addition, if I am uncomfortable for any reason, I may ask that the session be stopped immediately.
Draping will always be used during Aromatouch sessions. Any illicit or sexually suggestive remarks or advances made by me (the client) will result in the immediate termination of the session.

Client Signature: _____ Date: __ _____

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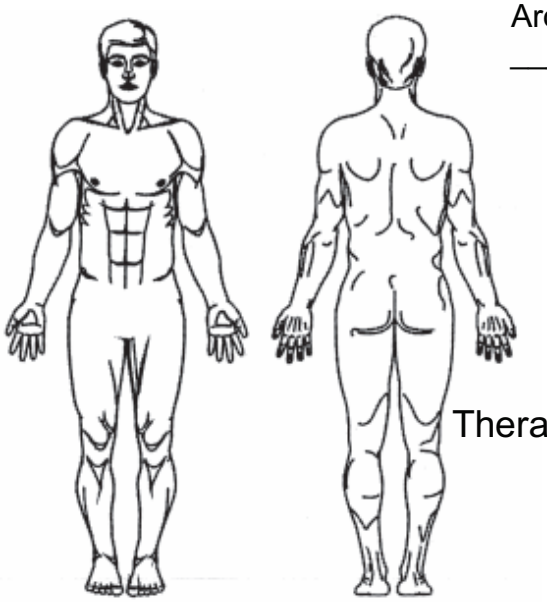
For Therapist Use:



Aromatouch to be performed today:

_____

On this diagram circles indicate the areas of the body that Aromatouch will be performed, and “X” indicates the areas of the body that will be avoided and the contraindications.

Therapist’s Signature: _____

Date: _____