Sacred Grove Healing Massage
David Peter Armentano L.M.T., M.M.P.
License # MT111247
(469) 285-9815
www.SacredGroveHealingMassage.com

Client Information

Name:_____ Home Phone:_____

Address:_____ City/State/Zip:_____

Cell phone:_____ Work Phone_____

Birth Date_____ Email :_____(we don't share email)

How did you hear about us: Dr._____?
Website_____ Yellow Pages _____ Other- (Please explain)_____

Occupation: _____ Employer: _____
Emergency Contact: _____ Phone:_____

What is your reason for today's visit? (I.e. relax, specific discomfort/pain)

_____

Have you ever had a professional massage before? Yes☐ No☐
Are you pregnant or trying to get pregnant? Yes☐ No☐
If yes, how far along are you? _____

PLEASE MARK IF YOU HAVE/HAD ANY OF THE FOLLOWING CONDITIONS:

☐Heart Conditions	☐High Blood Pressure	☐Vascular/Blood Disorders
☐Skin Disorders	☐Immune Disorders	☐Stomach Disorders
☐Diabetes	☐Cancer	☐Respiratory Disorders
☐Arthritis	☐Allergies	☐Broken Bones
☐Headaches	☐Back or Chest Aches	☐Sciatic Pain
☐Leg/Foot Pain	☐Neck/Shoulder Pain	☐TMJ Syndrome
☐Neuropathies	☐ Edema	☐Breast/Augmentation
☐ Dentures	☐Wear Contacts	☐ Allergies to oils/scent

☐Radiation / Chemotherapy treatment How long? _____

Do you Smoke? Select One Drink Alcohol? Select One Drink Caffeine? Select One
Drink Soda? Select One Eat Chocolate? Select One Use lots of salt? Select One

Exercise/ Stretching Habits? _____
How many times per week? _____ Duration? _____
Please advise us of any other health care professionals you have seen for this condition_____

Do you take any prescription medication? Select One if yes please list:
_____

Do you have any other medical issues including surgery that I should be aware of before giving you massage therapy? If yes, please describe._____

Please read the following, initial and sign below:

Select O I consent to Breast Massage of female clients **if** it is medically necessary
Select O We utilize conservative draping during our sessions
Select O If you feel uncomfortable for any reason you may ask to end the session.
Select O The types of techniques we use in the session, the parts of the body to be massaged, including indications /contraindications are determined during your initial visit / assessment and are fully explained by your Therapist.
Select O Be aware that our therapists are Licensed Massage Therapists with a wide variety of Advanced Training. However, we are not Physicians. If you have specific questions regarding your Medical Conditions, if any, please seek the advice of your Physician.

Select O I understand that Massage Therapy given here is for the purpose of, but not limited to: Fulfilling a prescription of a treating physician, for a medically necessary condition. For stress reduction, relief from muscular tension, spasm or for increasing circulation and energy flow. I understand that the Massage Therapist does not diagnose illness, disease, or any other physical or mental disorder. Massage therapy is not a substitute for medical examinations and/or diagnosis. It is recommended that I see a physician for any physical ailment that I might have.

Select O Because a Massage Therapist must be aware of existing physical conditions; I have stated all of my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Select O I will respect the time of my Massage Therapist(s) and other clients. I agree to come to my scheduled appointments promptly, barring any unforeseen emergency. I understand that if I cancel later than 4 hours prior to my appointment, I will have to pay HALF the cost of my appointment. If I NO SHOW, I will have to pay the FULL price of the appointment.

Client Signature: _____Date:_____

Therapist Signature:_____ Date:_____