SOUTHWIND

Health Collective LLC

Name ____ Date of Birth ___________

Address ____ City ___________ State ____ Zip ________

Phone (h) ______________________ (w) ___________________(c) ___________________________

Email _______________________________________ (used for occasional emails from us)

Have you received massage therapy or bodywork before? ______ How did you hear about us? _______

What are you hoping to gain from your session(s)? ____

If you have an injury, please describe ____

Are you under a doctor's care? _________ If so, name of physician _____________________________

Our lotions may contain nut oils. Sometimes we use essential oils. Do you have any allergies that we need to consider when working with you? ____

Please check any of the following that apply to you

__Skin Conditions	__Neck Pain	__ Asthma	__Contact Lenses
__ Low Blood Pressure	__Broken Bones(s)	__ Dentures	__ High Blood Pressure
__ Osteoporosis	__Varicose Veins	__Arthritis	__Recent Surgery
__Bleeding/Bruising	__Diabetes	__ Stress	__Heart attack/Stroke
__Seizure/Epilepsy	__ Anxiety/Depression	__Cancer	__TMJ
__Headaches	__Sinus problems	__Muscle sprain/strain	
__Respiratory problems	__Pregnant # of weeks ________		
__ Contagious Condition	__ Back pain (circle) low middle upper `		

__Vertebral Disc Problems (please describe) ____

I have completed this form to the best of my knowledge. I understand that a massage is for the purpose of stress reduction, relief from muscular tension or spasm, increased circulation, lymph flow, and energy flow. The massage therapist/bodywork practitioner does not diagnose illness, disease, or any other physical disorder. The therapist does not prescribe medical treatment or pharmaceutical treatment, nor do they perform spinal manipulations. I thoroughly understand that massage therapy is not a substitute for medical diagnosis or care. Because a massage therapist/bodyworker must be aware of existing medical conditions, I have stated all of my known medical limitations and am responsible to keep the therapist updated on my health. I agree to give 24 hours cancellation notice or to pay the cancellation fee established.

Client Signature _________________________________Date _______________Therapist Initials______

Parent or Guardian Signature ____

1045 Kentucky Street | Lawrence, KS 66044 **southwindhealthcollective.com**