YOUR BODYSOUL BALANCE & REJUVENATION MASSAGE INTAKE & HEALTH HISTORY FORM

BodySoul
Balance and Rejuvenation

Name _____ Email _____

Phone (cell/day) _____ DOB _____ Age: _____

Address _____ City/State/Zip _____

Emergency Contact Name _____ Phone _____ Relationship _____

Occupation _____ Referred by: _____

Health Information

Are you taking any medications? ☐ yes ☐ no If yes, please list: _____

Any allergies? (oils, lotions, nuts, fruits, skin, etc.) ☐ yes ☐ no If yes, please list: _____

Are you pregnant? ☐ yes ☐ no If yes, how many months: _____ Due date: _____

Are you you currently under medical supervision or receiving other medical interventions? ☐ yes ☐ no

If yes, please describe: _____

	No	Yes		No	Yes		No	Yes
Areas of swelling	☐	☐	Diabetes	☐	☐	Osteoporosis	☐	☐
Autoimmune disorder	☐	☐	Fibromyalgia	☐	☐	Phlebitis	☐	☐
Back / neck problems	☐	☐	Headaches	☐	☐	Sciatica	☐	☐
Bleeding disorders	☐	☐	Heart condition	☐	☐	Seizures	☐	☐
Blood clots	☐	☐	Hypertension	☐	☐	Stroke	☐	☐
Bruise easily	☐	☐	Kidney disease	☐	☐	Tendinitis	☐	☐
Bursitis	☐	☐	Multiple sclerosis	☐	☐	TMJ disorder	☐	☐
Cancer	☐	☐	Neurological condition	☐	☐	Varicose veins	☐	☐
Contagious condition	☐	☐	Neuropathy	☐	☐	Vertigo / dizziness	☐	☐
Decreased sensation	☐	☐	Osteoarthritis	☐	☐			

Areas of broken skin? (e.g. rash, wounds) ☐ yes ☐ no If yes, where? _____

History of joint replacement surgery? ☐ yes ☐ no Which joint(s) ? _____

Recent injuries or medical procedures in the past 2 years? ☐ yes ☐ no Please describe: _____

_____

Please describe any other injuries or health conditions: _____

Massage Information

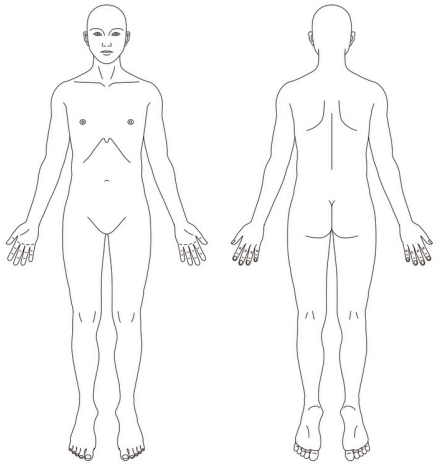
Have you had professional massage before? ☐ yes ☐ no How recently? _____

Reason for seeking massage: ☐ Relaxation ☐ Specific problem

_____

How much pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

Please indicate any areas of discomfort



The licensee, Yeghishe Boyajyan, is mandated to ensure that the breasts of all female clients are properly draped. Breast massage shall only be performed with written consent from the client prior to each session involving such procedures. Additionally, draping of the genital area and gluteal cleft must be maintained throughout the session for all clients.

Should a client engage in any verbal or physical contact of a sexual nature, the licensee is required to terminate the massage session immediately. Furthermore, if a client experiences discomfort for any reason, they may request the licensee to conclude the session, and the licensee will comply. The licensee also retains the right to end the session if they themselves feel uncomfortable for any reason.

It is important to note that massage therapy should not be viewed as a substitute for a medical examination or diagnosis. Clients are advised to consult a physician regarding any physical ailments. I acknowledge that the massage therapist does not prescribe medical treatments or medications and does not perform spinal adjustments. Additionally, I understand that if I have a serious medical condition, I must provide written consent from a physician before receiving services.

Massage therapy should not be viewed as a substitute for professional medical advice. If you are experiencing any discomfort, please notify me immediately and seek appropriate medical care. We can easily reschedule your appointment as needed. Given that certain medical conditions may contraindicate massage therapy, I affirm that I have truthfully answered all questions regarding my medical history.

By signing below, I acknowledge my understanding of the benefits and risks associated with massage therapy, and I certify that I have completed this form to the best of my knowledge. Additionally, I agree to inform my massage therapist, Yeghishe Boyajyan, LMT, of any changes to my health or medical status.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____