REVIVE

MASSAGE•COSMETOLOGY•PHOTOGRAPHY

Name: _____ Date of Birth: ____/____/____
Initial Service Date: ____/____/____
Address: _____ City: _____ State: _____
Zip Code: _____ Phone: (day) _____ (evening) _____
Occupation: _____ Employer: _____
Referred By: _____
Physician Name: _____ Physician Phone Number: _____
Emergency Contact: _____ Phone Number: _____

Previous Massage Experience:

_____
_____
_____

Primary Reason for Appointment / Areas of Pain or Tension:

_____
_____
_____

Please Mark (X) for all conditions that you are currently experiencing. Put (P) for Past conditions. Put (F) for Family history illness.

__Headaches or Migraines
__Chronic Pain
__Muscle or Joint Pain
__Numbness or Tingling
__Sprains or Strains
__Arthritis or Tendonitis
__Cancer or Tumors
__Spinal Column Disorders
__Diabetes
__Pregnancy
__Heart or Circulatory Problems
__Fatigue
__Tension or Stress
__Depression
__Sleep Difficulties
__Allergies
__Rashes or Athlete's Feet
__Infectious Disease
__Blood Clots
__Varicose Veins
__High / Low Blood Pressure
__Vision Problems or Contact Lenses
__Hearing Problems or Deafness
__Injuries to Face or Head
__Sinus Problems
__Dental Bridges
__Jaw Pain or TMJ Problems
__Asthma or Lung Conditions
__Constipation or Diarrhea
__Hernia
__Birth Control or IUD
__Abdominal or Digestive Problems
__Other Medical Conditions Not Listed (explain on back side of page)

Explain Any Areas Listed on Previous Page or Any Medical Conditions / Surgeries Not Listed:

_____
_____
_____

Current Medications, Including Aspirin, Ibuprofen, Herbs, Vitamins, Etc:

_____
_____

Please list all forms and frequency of stress-reduction activities, hobbies, exercises, or sports:

_____
_____

Therapeutic Massage Consent: I understand that the massage I receive is for the basic purpose of relaxation, stress reduction, and relief of muscular tension. If I experience pain or discomfort during the massage, (besides trigger point therapy) I will inform my massage therapist so that the pressure and or strokes may be adjusted to my level of comfort.
I further understand that the massage shouldn't be construed as the substitute for a medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment I am aware of. I understand that the therapist aren't to perform skeletal or spinal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session(s) should be construed as such.
I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep my therapist updated as to any changes in my medical profile, and understand that there shall be no liability on Revive LLC. should I forget to do so.
I understand that any illicit or sexually suggestive remarks or advances made by the client will result in full payment and immediate termination of the session.
I understand that the scheduled massage session time includes dressing and undressing. The actual hands on time may be 10 minutes less than the duration of the massage.
Under NO circumstances will the client's personal information be discussed or released unless written authorization has been given by the client.

Payment Policy: We Accept Cash, Check, MasterCard, Visa, and Discover. Please Make Checks Payable to Revive LLC.
Returned Check Policy: If the Bank dishonors a check, we will not re-deposit it. You must pay in cash, the check amount plus a $35 returned check fee reimbursement to Revive LLC. The fee will be assessed for each bank-returned check, including checks on which payment has been stopped. We will also NO LONGER accept checks from you and you must pay in cash for any future massages.

Right to Refuse: We reserve the right to refuse potential clients for no reason.

I have read and agree to the above.

Signature: _____
Date: ____/____/____

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Date: ____/____/____

Client Name: _____

Gender: Male / Female

Pain Intensity: 1-10 Pre Session: ____ / Post Session: ____

Service: Corporate Chair Deep Muscle
Pre-Natal Sports
Stone Swedish
Trigger Point

Duration: 30 / 60 / 90

Comments On Appointment:

_____
_____
_____

Payment: Cash / Check / Credit

Amount: _____

Client Signature: _____

Therapist Signature: _____

REVIVE LLC.
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