Avante' Laser and MediSpa
Massage Therapy Confidential Client History

Last Name:______________________ First Name:_______________ Middle Initial: ___
Street Address: ____ Apt. #: ____________
City: ______________________________ State: ____________ Zip Code: _____________
Home Phone: ____________________________ Work Phone: _______________________
Can we call to confirm appointments? Yes No # __________________________________
Email Address: ______________________________ Date of Birth: ___________________
Occupation: ______________________________ Employer: _________________________
How were you referred to our office? (please circle below):
Person Physician Newspaper Phone Book Drive by Other
Who can we thank for referring you to our office? ______________________________
Type of massage requesting: _____Relaxation ___ Firm Pressure ___Deep Tissue
Specific Regions to focus on: ____

Please list all medications you are currently taking: _________________________________
____
____
Please list all medical conditions: ____
____
Operations you have had and dates: ____
____

Have you had a professional massage before? _____ Yes ____ No
Are you Pregnant? ____ Yes ____ No
Do you have any of the following?
Contacts in eyes Y N Spinal Problems Y N Varicose Veins Y N
Arthritis Y N Cancer Y N Heart Condition Y N
High Blood Pressure Y N History of Blood Clots Y N
Circulation Problems Y N Pain that travels down your legs/arms Y N
Allergies to any Lotions, Oils, or Fragrances Y N (specify)________________________

I understand that the massage therapy given here is for the purpose of stress reduction, relief from muscular tension, spasm, or to increase circulation. I understand that draping will be used during the session. I understand that if I am uncomfortable for any reason, I may ask the therapist to cease the massage and the therapist will end the massage session. I understand that this is a full-body massage with exception of the areas of the body that are to be avoided per prior indications and /or contradictions. I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist prescribes neither medical treatment nor pharmaceuticals, nor performs any spinal manipulations. It has been made very clear to me that this massage therapist not be a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I may have.

Signature: __________________________ Date: _____________ Therapist: __________________________