

# Bonnie Barrow, LMBT

## Confidential Client Information

### Personal Information:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Emergency Contact #: \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_

Activities/ Hobbies of Interest \_\_\_\_\_

Have you had professional massage therapy before? \_\_\_\_\_

If yes, what was your experience of the massage?

\_\_\_\_\_

What goals do you have for your overall health?

### Current Conditions:

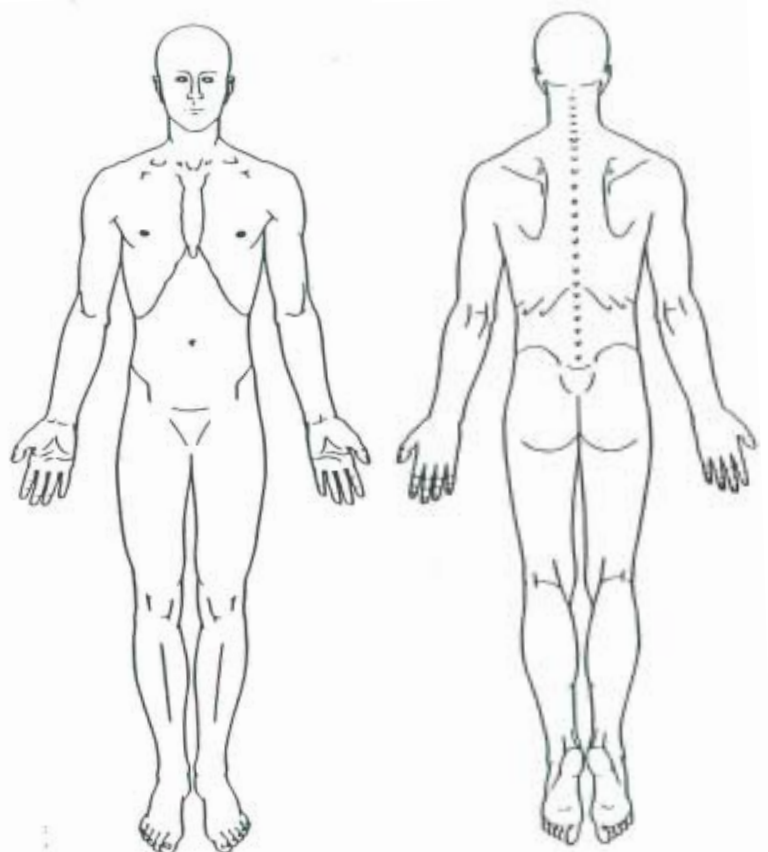
Please Label on the body models any areas of pain, joint or muscle stiffness and/or tension, areas of numbness or tingling or any scars, bruises or open wounds.

How did this condition develop?

What makes it worse?

What makes it better?

Describe your physical activities at work/home:



# Bonnie Barrow, LMBT

## Confidential Client Information

### Medical Information:

Are you currently being treated by any health care providers such as a medical doctor, chiropractor or mental health therapist? **Y N**

If yes, please state your health care provider and the reasons why.

Are you currently taking over the counter, prescription medications or supplements? **Y N**

If yes, please list medications then what the medications are for:


Please check any condition(s) that apply to you and be descriptive when appropriate:

Heart Condition	Convulsions	Eliminatory Problems
High / Low Blood Pressure	Muscle/Joint Pain	Skin Problems
Depression	Osteoporosis	Digestive Problems
Constipation	Arthritis	Respiratory Problems/Asthma
Diabetes	Headaches	Infectious Diseases
Cancer	Circulatory Problems	Dizziness
Blood Clots/Phlebitis	Spinal/Skeletal Problems	Fatigue
Pregnancy	Allergies/Foods, Scents	Insomnia
Contact Lenses	Bridgework	Hair Piece / Wig
Other		

Descriptions of the above conditions please use the back of this page if needed:


Describe past injuries, accidents and surgeries. Include areas of the body, dates and treatments:


Are there any areas of your body where you experience discomfort regularly? If yes, please describe below: \_\_\_\_\_


# Bonnie Barrow, LMBT

## Confidential Client Information

Dear Client,

Please take a moment to carefully read the following information and sign where indicated:

I understand and agree that 1) the massage therapy that I am given is for the purpose of stress reduction, relief from muscular tension/spasm, and/or for improving circulation; 2) a massage therapist neither diagnoses illness, disease or any other medical, physical or mental disorder, nor performs any spinal manipulations; 3) I am responsible for consulting a qualified physician for any physical ailments that I may have.

Because massage therapy should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and physical limitations, and answered all my questions honestly because a massage therapist must be aware of any existing physical conditions. And, I will inform my massage therapist of any changes to this information prior to receiving future treatments and understand that there shall be no liability on the massage therapists part should I neglect to do so.

All massages are nonsexual. I understand that if I should make advances towards the therapist or have sexual intentions related to this session or any future sessions, the therapist has the right to terminate the massage session, and I will be liable for payment of the scheduled appointment.

**Please make sure you have read the policy below in regards to cancellations, rescheduling and tardiness to your appointments. I want to be sure that I have been clear about my intentions and if you have any questions I can address those questions now rather than later.**

**I agree that all services rendered to me are charged directly to me and I am responsible for payment unless prior arrangements have been made. I agree to pay for all scheduled appointments that I am unable to keep unless I notify my massage therapist at least 24 hours in advance.**

**I agree and understand that any cancellation within that 24 hour period before my scheduled appointment will make me responsible for immediately rescheduling another appointment at the time of cancellation; otherwise I am responsible for the payments of the originally scheduled appointment.**

**I agree and understand that in the event I am late to my appointment, I will not receive the full amount of time on the table and I will be responsible for the full payment of the originally scheduled amount of time on the table for my appointment.**

Thank you for your time and I look forward to working with you.

Sincerely,

Bonnie Barrow, LMBT  
NC License# 6679

---

Client's Signature

---

Date