

Alpha Omega Massage Therapy

Personal Information

Today's Date _____

Name: _____

Address: _____

City, State Zip: _____

Daytime Phone: _____ Cell Phone: _____

Evening Phone: _____

Occupation: _____

Email: _____

Emergency Contact Name & # _____

Interested in our Newsletter or discounts? Yes No

Height: _____ Weight: _____ Date of Birth: _____

Have you had a massage before? Yes No

How Often? _____ When was your last? _____


What **did** you like? Music, scents, oil, cream or heat?

What did you **not** like? Music, scents, oil, cream or heat?


Level of Pressure Preferred? light medium firm deep

- Please feel free, at any time to ask for a change in pressure, temperature, music or lighting. I **need** your honest feedback and it is not considered complaining!

Back



Front



Circle areas of pain or discomfort

D o N o t M a s s a g e	<input type="checkbox"/> back	<input type="checkbox"/>	E x t r a A t t e n t i o n
	<input type="checkbox"/> arms	<input type="checkbox"/>	
	<input type="checkbox"/> hips	<input type="checkbox"/>	
	<input type="checkbox"/> buttocks	<input type="checkbox"/>	
	<input type="checkbox"/> legs	<input type="checkbox"/>	
	<input type="checkbox"/> feet	<input type="checkbox"/>	
	<input type="checkbox"/> stomach	<input type="checkbox"/>	
	<input type="checkbox"/> face	<input type="checkbox"/>	
<input type="checkbox"/> scalp	<input type="checkbox"/>		
<input type="checkbox"/> neck	<input type="checkbox"/>		

Medical Info (Check box NOW-Circle PAST)

<input type="checkbox"/> Angina	<input type="checkbox"/> Epilepsy / Seizures
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Joint Swelling
<input type="checkbox"/> Claustrophobic	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Contact Lenses	<input type="checkbox"/> Ticklish
<input type="checkbox"/> Dentures	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Any contagious disease (especially of the skin)	
<input type="checkbox"/> shingles	<input type="checkbox"/> rashes <input type="checkbox"/> Poison Ivy/ Oak
<input type="checkbox"/> Allergies	<input type="checkbox"/> seasonal <input type="checkbox"/> food <input type="checkbox"/> medicinal
<input type="checkbox"/> Asthma.....	Last attack? _____
<input type="checkbox"/> Blood Clots	When? _____
<input type="checkbox"/> Cancer	Type? _____
<input type="checkbox"/> Diabetic.....	<input type="checkbox"/> Type I <input type="checkbox"/> Type II
<input type="checkbox"/> Gout.....	Last attack? _____
<input type="checkbox"/> Headaches	<input type="checkbox"/> sinus <input type="checkbox"/> migraine <input type="checkbox"/> cluster
<input type="checkbox"/> Hepatitis.....	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C
<input type="checkbox"/> Pregnant.....	Months _____ <input type="checkbox"/> Nursing?
<input type="checkbox"/> Tested Positive	<input type="checkbox"/> HIV <input type="checkbox"/> AIDS

Additional Medical Information (continue on back)

Accidents, broken bones or surgeries, in the past 2 years

Any other medical condition I should be aware of

List any medications and the reason you take them

Are you under a physicians care? Yes No
Who? _____

Are you under a chiropractors care? Yes No
Who? _____

What makes it better? _____

What makes it worse? _____

How did you find us? (check all that apply)

Someone referred me _____

Flyer from _____ Car Advertising

Jo Co Yellow Pages www.smartpgs.com

Friend of the therapist ww.aomassage.com

Other _____

IMPORTANT - PLEASE READ

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will inform the therapist immediately so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork is not a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical professional for any mental or physical ailment of which I am aware. I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any mental or physical illness. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. I agree to give 3 hours advance notice of a cancellation of my scheduled session. I will be liable for payment of the scheduled appointment if I am unable to give 3 hours advanced notice.

Client Signature _____

Date _____

Directions

11800 Shawnee Mission Parkway, Suite 4
Shawnee, KS 66203

- 1.) Take the Shawnee Mission Parkway exit: East of 435 or West of I-35
- 2.) The North East corner of Shawnee Mission Parkway & Quivira, between Blockbuster & Boston Market
- 3.) Parking lot is in the back of the building,
- 4.) Entrance is the white middle door in the back of the building
- 5.) Go down the stairs (on the right),
- 6.) Suite #4, last door on the left

Please arrive on time for your scheduled appointment.

To stay on schedule, I will shorten the massage session to adjust for late arrivals.

If you are going to be late or need to reschedule please call 913.522.6888.

You will be responsible for payment of missed sessions if you do not give at least 3 hours notice.

Energy Work

I do a few minutes of energy work in addition to your scheduled time at the end of each session. This is a hold under your neck in which you may or may not feel anything. This may include heat, tingling or pain leaving. If nothing else, it is deeply relaxing.

Before Your Massage

Do you need to use the rest room?

Please turn off cell phones, pagers and PDA's.

Remove gum, jewelry, glasses and hard contact lenses prior to the session.

Talking is controlled by you, some clients do not talk so they can relax totally and others prefer small talk.

Do I have to take off all my clothes? Some clients choose to leave on their underclothes; other clients prefer to completely disrobe. It is your choice; your modesty will always be respected. You will then be under a warmed flannel sheet and blanket. Only the body part that is being worked on will be uncovered.

I usually use almond oil, scented with lavender essential oil. If you prefer I also have Biotone cream.

I have many massage cds if you would prefer something else, just ask.

After a massage some clients feel chilled; please bring a sweater or jacket to go home in, just in case.

Payment

Payment – Cash, Checks, MasterCard and Visa are accepted. Tips are at your discretion.

website: www.aomassage.com

email: beckyfritz@everestkc.net