Aloha Healing LLC

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Client Agreement

I, whose name is printed on the Client Health Information which is on the back side of this sheet, understand that the massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Any other intended purposes for massage therapy are specified below:

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and massage therapists do not diagnose illness or disease and do not prescribe medications.

I understand that massage therapy is contra-indicated for some medical conditions, and the massage therapist, the practitioner or Aloha Healing LLC (AHLLC) may refuse service for my protection.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. I agree to release the massage therapist, the practitioner and AHLLC from any liability due to my forgetting to relay any pertinent information.

I understand and agree to abide by the therapist's polices and will not hold the therapist, the practitioner or AHLLC responsible for any personal injury or loss of property.

_____ _____

Client Signature Date

Client Health Information

Print clearly and complete both sizes of this form.
All information disclosed will be kept strictly confidential.

Name: _____ Date: _____

_____

Address City State Zip Code

Home Phone: (_____) _____ - _____ Cell/Work phone: (_____) _____ -_____

Email: _____ Date of Birth: _____

Please circle any painful or tense areas as well as regions that hold your stress:

Head | Neck | Shoulders | Upper Back | Lower Back | Hip | Thighs | Calf | Feet | Arms | Hands |

Others (Please specify): _____

Are you pregnant? Yes / No

Please circle any of the following health issues that you have had in the past year:

Allergies	Cardiac Issues	Irritable Bowel Syndrome	Stroke
Sciatica	Asthma	Varicose veins / Clots	Insomnia
Fibromyalgia	Diabetes	Migraines / Headaches	Joint Issues
Whiplash	Cold / Flu	High Blood Pressure	Skin Conditions
Osteoporosis	Bruise / Edema	Broken Bones	Injuries

Others (Please Specify): _____

_____

_____

List medications you take: _____

_____