CONFIDENTIAL CLIENT REGISTRATION

Name:		Today's Date:	
Street address:		City:	Zip Code:
Home phone no.:	Cell Phone no.:	Email Address:	
Have you ever received professional massage before? ❑ Yes ❑ No		Date of last massage (if known):	
What are your goals for today's session? Examples: Relaxation, Relieve Tight Muscles, Relieve Headaches			
Do you have any allergies to body lotion, gel or oil? ❑ Yes ❑ No		Any Difficulty lying face down?	❑ Yes ❑ No

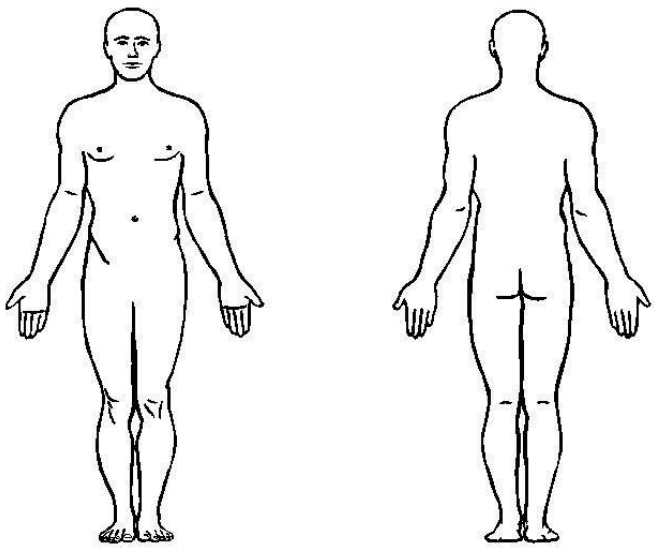
Please indicate if you have any of the following conditions:

❑ Contagious skin condition	❑ Current fever or swollen glands
❑ Open sores or wounds	❑ High or low blood pressure (circle)
❑ Osteoporosis	❑ Varicose veins
❑ Epilepsy	❑ Deep Vein Thrombosis
❑ Diabetes	❑ Cancer (Please give details on pages 3-4)
❑ Decreased/Increased sensation	❑ Allergies? List: _____
❑ Back concerns	❑ Frequent Headaches
❑ Pregnant	❑ Arthritis
❑ Recent Accident or Injury	❑ Spinal Problems
❑ Asthma	❑ Jaw Pain (TMJD)
❑ Joint disorder or artificial joint	❑ Other (Please indicate) _____

Please indicate any medications, vitamins or herbs you take, and the conditions they address:	
Other concerns/diagnoses/conditions I should know about:	

Emergency Contact: Relationship to you: Phone Number:

In the diagram on the right, please circle any areas of discomfort that need special attention:



I have read and understand the Tender Loving Care Client Agreement and agree to its contents (see page 2):

_____
Name(print)

_____
Signature

Client Agreement

- I understand that the therapist may be touching, rubbing, compressing and/or kneading my skin and body using various massage techniques. I am voluntarily participating in this activity and understand and agree that my therapist is not responsible for the aggravation of conditions that were present, but not disclosed, at the time of the treatment and may be affected by such treatment. I am aware that this is a release of liability and that the therapist is relying on my waiver and release of potential claims in agreeing to provide me with the services that I have requested.

- I understand that massage therapy is non-sexual and my session may be terminated immediately for inappropriate requests, language or behavior, with full payment due.

- I agree to give 24-hour notice for a scheduled session that I cannot keep and will be charged the full amount for any missed sessions.

Therapist Agreement

As a California Massage Therapy Council Certified Massage Therapist (license #22264) and member of Associated Bodywork & Massage Professionals, Gina Moore agrees to the following Code of Ethics:

Client Relationships

- I shall endeavor to serve the best interests of my clients at all times and provide the highest quality service.
- I shall maintain clear and honest communications with my clients and shall keep client communications confidential.
- I shall acknowledge the limitations of my skills and, when necessary, refer clients to the appropriate qualified health care professional.
- I shall in no way instigate or tolerate any kind of sexual advance while acting in the capacity of a massage, bodywork, or somatic practitioner.

Professionalism

- I shall maintain the highest standards of professional conduct, providing services in an ethical and professional manner in relation to my clientele, business associates, health care professionals, and the general public.
- I shall respect the rights of all ethical practitioners and will cooperate with all health care professionals in a friendly and professional manner.
- I shall refrain from the use of any mind-altering drugs, alcohol, or intoxicants prior to or during professional sessions.
- I shall always dress in a professional manner, proper dress being defined as attire suitable and consistent with accepted business and professional practice.
- I shall not be affiliated with or employed by any business that utilizes any form of sexual suggestiveness or explicit sexuality in its advertising or promotion of services, or in the actual practice of its services.

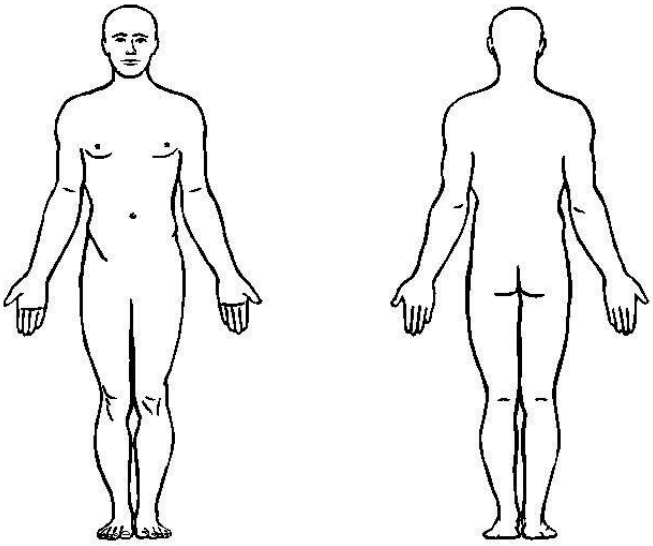
Scope of Practice / Appropriate Techniques

- I shall provide services within the scope of the ABMP definition of massage, bodywork, somatic therapies and the limits of my training. I will not employ massage or bodywork techniques for which I have not had adequate training and shall represent my education, training, qualifications and abilities honestly.
- I shall be conscious of the intent of the services that I am providing and shall be aware of and practice good judgment regarding the application of techniques utilized.
- I shall not perform manipulations or adjustments of the human skeletal structure, diagnose, prescribe or provide any other service, procedure or therapy unless specifically licensed to do so.

Advertising Claims

- I shall practice honesty in advertising, promote my services ethically and in good taste, and practice and/or advertise only those techniques for which I have received adequate training and/or certification. I shall not make false claims regarding the potential benefits of the techniques rendered.

CONFIDENTIAL ONCOLOGY HISTORY

Name:	Today's Date:
Approximate date of first diagnosis:	Type of cancer:
Where was cancer located?	Present status of cancer:
Name of Oncologist:	Date of last visit:
Surgery/Procedure TYPE: DATE: TYPE: DATE: TYPE: DATE:	
Lymph Nodes Removed: Number (if known) _____ Where_____ Please indicate on diagram to the right where lymph nodes were removed:	
Reconstruction (Procedure, Approx. Date):	
Chemotherapy: Are you currently receiving chemotherapy? ❑ Yes ❑ No	Date of last Chemotherapy treatment:
Radiation: Are you currently receiving radiation treatments? ❑ Yes ❑ No	Area treated: Nodes irradiated in armpit, neck or groin? ❑ Yes ❑ No
Other: Please list any other treatments or medical devices:	
Please continue to Page 4	

CONFIDENTIAL ONCOLOGY HISTORY (CONTINUED)

Side Effects: Please circle any CURRENT conditions. Please underline PAST conditions.

General: Fatigue Anxiety Depression Allergies Systemic Infection Infectious Condition Dizziness

Skin: Fragile Skin Radiation skin reaction Dry skin Skin irritation Hair loss

Musculoskeletal: Touch/pressure sensitivity Bone pain Incision Headache Former Injuries Pain

Decreased range of motion Joint problems Joint replacement Adhesions Osteoporosis

Gastrointestinal: Nausea Vomiting Low Appetite Mouth sores Weight Loss Weight Gain

Diarrhea Constipation

Nervous System: Burning/Itching/Tingling/Numbness in Hands/Arms/Legs/Feet Memory Problems

Circulatory: Bruise easily Blood Clot Low Platelet count Low Red Cell Count Low White Cell Count

Edema Lymphedema High Blood Pressure Excessive hot/cold Heart condition Lung Condition

Current Medications:

Drug Name	*Purpose*	*Side Effects*

Thank You