Angel Light Therapeutic Massage LLC
George Ann Betts CMT, BCTMB
9 S Huntersville Rd, Batesville IN 47006
812-363-5906

PERSONAL CONTACT INFORMATION

Name: _____ Date of Birth: _____
Address: _____ Phone #: (____) _____
City/State/Zip: _____ Email: _____
Emergency Contact & Phone #: _____

MASSAGE HISTORY / PREFERENCES

Have you received professional massage before? □Yes □No If yes, date of last massage: _____
What results do you want from your session(s)? _____
What areas would you like prioritized? _____

MEDICAL HISTORY

Major Illnesses, accidents and/or injuries: _____

Please check any of the following that may apply: □Wear contact lenses □Communicable Illness
□Open sore/wound □Infection or inflammation □Pregnant □Allergies to oils or lotions

Check any of the following conditions that you are experiencing or have experienced in the past:

	Current	Past		Current	Past
Heart condition	□	□	Arthritis	□	□
High Blood Pressure	□	□	Low Back Pain	□	□
Low Blood Pressure	□	□	Sciatica/ Numbness	□	□
Varicose Veins	□	□	Poor Circulation	□	□
DVT/blood clots	□	□	Migraines/ Headaches	□	□
Neck/ Spinal Injury	□	□	Ovarian/ Menstrual Problems	□	□
Osteoporosis	□	□	Kidney/ Bladder Problems	□	□
Diabetes	□	□	Bursitis/ Tendonitis	□	□
Cancer	□	□	Insomnia	□	□
Hay fever/ Allergies	□	□	Digestive Problems	□	□
Respiratory Problems	□	□	Skin Disorders	□	□
Fibromyalgia	□	□	Herpes/ Shingles	□	□
Chronic Pain	□	□	TMJ/Jaw Pain	□	□

Please note any other medical condition that is affecting you: _____

Are you currently under the care of a physician for any of the above conditions? □ Yes □ No

Please list any medications you are taking: _____

_____

over

- I understand that massage therapy is for general wellness purposes and relief of muscle tension, and I should see a health care provider for diagnosis and treatment of medical problems.
- It is my responsibility to inform my therapist of any changes in my health history or medication.
- I recognize that I am responsible for keeping my scheduled appointments and I agree to pay for the treatments at the time of service.
- I also understand that if I fail to keep my scheduled appointment I will be responsible for the cost of the therapist's time.
- All information provided is confidential except in the event that I may be of harm to myself or others.
- Massage therapy is strictly therapeutic and therefore strictly non-sexual.

I have received and read a copy of the Office Policies and Procedures for Angel Light Therapeutic Massage.

_____ _____

Signature Date

Circle any specific areas you would like the massage therapist to concentrate on during the session: