

*Angel Light Therapeutic Massage LLC  
George Ann Betts CMT, BCTMB  
13 E George St - Ste D, Batesville IN 47006  
812-363-5906*

**PERSONAL CONTACT INFORMATION**

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

**MESSAGE 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	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica/ Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>
DVT/blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Migraines/ Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Neck/ Spinal Injury	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian/ Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/ Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis/ Tendonitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever/ Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Herpes/ Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	TMJ/Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>

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: \_\_\_\_\_  
 \_\_\_\_\_

- 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:**

