RAC
RAINTREE ATHLETIC CLUB

Massage Client Information

Name: _____ M / F DOB: _____

Phone: _____ Email Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Referred By: _____

Emergency Contact: _____ Phone: _____

Females Only: If pregnant please list your due date? _____

Have you ever experienced Professional Massage? Y/N How long ago? _____

Medical Information: Mark (C) if you currently suffer, or have in the past (P) any of the following:

____ Allergies	____ Anemia	____ Arthritis
____ Back/Disk Problems	____ Blood Clots/phlebitis	____ Cancer
____ Bruise Easily	____ Varicose Veins	____ Carpal Tunnel
____ Chest Pains	____ Diabetes	____ Digestive Issues
____ Dizziness/Fainting	____ Edema	____ TMJ
____ Fatigue	____ Fibromyalgia	____ Headaches/Migraines
____ Heart Condition	____ Hemophilia	____ Tendonitis
____ HIV +/AIDS	____ Hip/Knee Replacement	____ Kidney Disorder
____ Limited Joint Movement	____ Liver Disorder	____ Loss of Balance
____Lung/Breathing Disorder	____Muscle Spasms	____ Neck Problems
____ Osteoporosis	____ Swollen Joints	____ Pinched Nerve
____ Sciatica	____ Seizures/Convulsions	____ Shingles
____ Sinus Infections	____ Sleep Disorder	____ Sprains/Strains
____ H/L Blood Sugar	____ H/L Blood Pressure	

Other_____

If you answered "yes" to any of the above questions, please explain as clearly as possible below.

_____

_____

_____

Any Skin Conditions (Rashes, Cuts, Fungus etc.):_____

Currently on these Medications: _____

Contact Lenses: Y/N

Describe any Surgeries, Accidents, and Hospitalizations etc:

_____

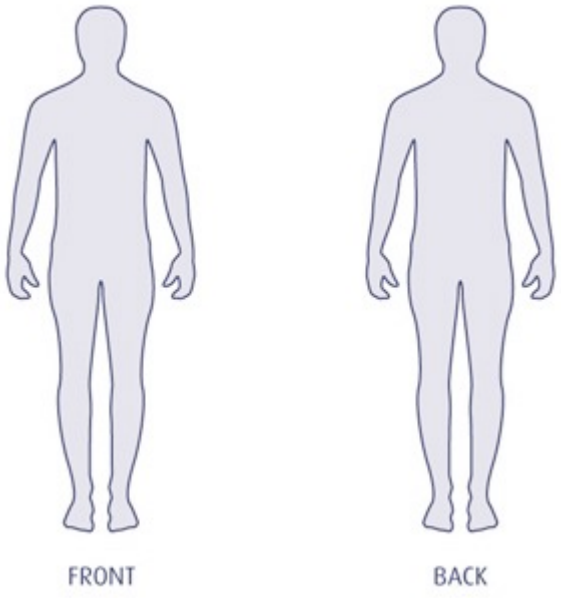
_____

Daily Stress Level: Level (1-10):_____ Cause:

_____

Do you exercise? Y/N How often? _____

Please 'X' below where tension is held.



Consumed alcohol in the past 24 hours? Y/N

Do you smoke? Y / N

Socially Light Heavily

How much water do you drink daily (in oz) _____

Do you want your stomach massaged? Y/N Chest? Y/N

Any areas you do NOT want worked? _____

Depth of pressure preferred?

Light Medium/Firm Deep

What is/are your main goals for the session today? _____

_____

CANCELLATION OR MISSED APPOINTMENTS

Please understand that your time commitment begins at the moment you reserve a massage. In order to make it fair for everyone, please consider your schedule carefully. There are times when a cancellation is, of course, necessary. Please give a min of 24 hours notice whenever possible. If you miss or cancel an appointment (medical emergencies excluded) without twenty-four (24) hour notice, you will be charged the full cost for the missed session.

Client Signature_____ Date_____

Parent/Guardian (if under 18 yrs. of age) _____

Therapist Signature_____ Date_____

MASSAGE SERVICES

ACKNOWLEDGEMENT OF RISK, RELEASE OF LIABILITY AND AUTHORIZATION

I am applying for admission to the Raintree Athletic Club Wellness facility and being fully aware that this activity involves risks, I accept the risks of participating in massage, even if they are created by the carelessness or negligence of Raintree Athletic Club employees, volunteers, agents, independent contractors, contract-employees or any other personnel in any way assisting or connected with massage services.

I fully release, discharge and waive any Claims I may have, now or in the future, against Raintree Athletic Club, its employees, officials, volunteers, agents, independent contractors, contract-employees and any other personnel in any way assisting or connected with massage services.

I have truthfully answered the questions set forth on the client information form and agree to keep the practitioners at Raintree Athletic Club advised of any and all relevant medical conditions. No warranties have been made to me about the benefits of therapeutic massage. I understand that Raintree Athletic Club's massage therapists cannot diagnose medical conditions or prescribe medications. I understand and intend that this document act as the broadest and most inclusive assumption of risk, waiver, release of liability, agreement not to sue and indemnify as is permitted by the laws of the State of Colorado.

If necessary, I authorize Raintree Athletic Club's massage therapists to contact and release information regarding my condition or treatment to my physicians and surgeons, as it applies to my massage treatment.

If the patient is under 18 years of age, the parent agrees to the following statements: as a parent or guardian of the patient, I authorize the child to receive massage therapy. I also join in the statements and agreements made by the released parties in this document. I also agree that, in the event the child or anyone acting on his or her behalf should make any Claims, I will provide indemnity and hold harmless Raintree Athletic Club, its employees, volunteers, agents, independent contractors, contract-employees and any other personnel in any way assisting or connected with massage treatment, even if injury arises from the carelessness or negligence of Raintree Athletic Club employees

Please sign here after reading entire waiver:

Print Name: _____ Date: _____

Signature: _____ Date: _____

Parent's Signature (if you are under 18) : _____ Date: _____

EXPIRATION: Unless earlier revoked, this authorization will expire one year after the date of this release.

PATIENT RIGHTS: I have the right to inspect or copy the information to be disclosed as provided in 45 CFR 164.524. I have the right to inspect and amend my medical records as provided in 45 CFR 164.526. I have the right to an accounting of the use and disclosure of my health information to any third party as provided in CFR 164.528.

RE-DISCLOSURE: I understand that there is a potential for unauthorized re-disclosure of the information and that the re-disclosed information may not be protected by federal confidentiality rules.