

The Gift of Touch, LLC
Kimberly Ann Bagley, LMBT #3405
919-789-1693

Your answers to the following questions will be kept confidential. They will be seen only by myself and are requested so that I may provide you with better care.

Name _____ Date _____

Address _____ Phone(day) _____

City _____ State _____ Zip _____ Phone(eve) _____

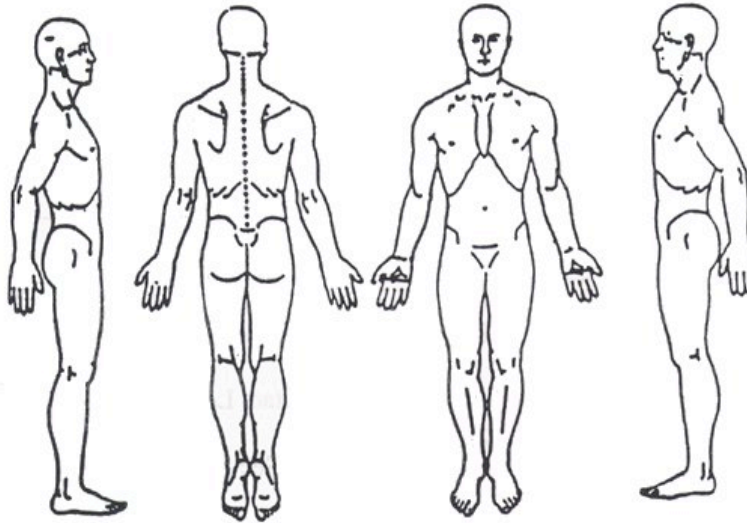
Age _____ D.O.B. ____/____/____ Sex _____ Pregnant? _____ E-Mail Address _____

Occupation _____ What do you do for exercise? _____

For relaxation? _____ Have you received previous massage work? _____

Any specific areas you would like worked on? _____

Any major traumas you have had to your body (e.g. accident, fall, etc.). Please include ALL muscle, bone or joint injuries even if not recent: _____



You may use the chart to indicate areas of discomfort or desired areas to work on.

Allergies? _____ Drugs (prescription/recreational)? _____

Are there any specific medical conditions I should be aware of? (ex. Athlete's Foot, High Blood Pressure, Seizures)

Is there anything else I should know?

The following sometimes occur during massage. They are normal responses to relaxation and/or touch, and you need not be embarrassed nor should you suppress any of these responses. Movement or release of intestinal gas - crying - laughing - strong emotions - sighing - groaning - yawning - softening of muscle tissue - cognitive or felt memories - stomach gurgling - need to move or change position. At any time during your session please let me know if there is anything I can do to help you feel more comfortable.

I understand that the services provided are not a replacement for medical or psychological care and that any information provided is not prescriptive or diagnostic in nature. I also understand that behavior of a sexual nature is inappropriate and will result in the session being terminated with full payment due.

Client's Signature _____

Date ____/____/____