



*Healing Hands  
Massage Therapy*

**Betty Brandemarte, Licensed Massage Therapist**

1610 West Street, Suite 201, Annapolis, MD

410-991-4577 Office 410-757-1184 Home

**CLIENT INFORMATION SHEET & RELEASE FORM**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE (H) \_\_\_\_\_

(W) \_\_\_\_\_

OCCUPATION \_\_\_\_\_ (C) \_\_\_\_\_

Email \_\_\_\_\_

ARE YOU PRESENTLY UNDER A DOCTOR'S OR THERAPIST'S CARE?

IF SO, FOR WHAT \_\_\_\_\_

HAVE YOU EVER HAD A PROFESSIONAL MASSAGE OR OTHER TYPE OF BODYWORK? \_\_\_\_\_

IF SO, WHAT KIND(S)? \_\_\_\_\_

WHAT DO YOU HOPE TO GAIN FROM MASSAGE?

Please circle any of the following areas which you would like worked on.

BACK

NECK

LEGS

ARMS

ABDOMEN

FACE

CHEST

FEET

HANDS

GLUTEUS

Please circle any of the following which presently apply to you.

ARTHRITIS

CANCER

AIDS/HIV+

PHLEBITIS

BLOOD PRESSURE

BONE INJURY

COLD OR FLU

DIABETES

BLOOD CLOTS

VARICOSE VEINS

DISC PROBLEM

HEART DISEASE

HEADACHES

INFECTION

RECENT SURGERY

JOINT INJURY

OSTEOPOROSIS

PREGNANCY

ALLERGIES

SKIN CONDITION

TAKING MEDICATION: Please list \_\_\_\_\_

ANY OTHER CONDITIONS: Please describe \_\_\_\_\_

OLDER INJURIES THAT STILL AFFECT YOU: \_\_\_\_\_

EXERCISE REGIME: \_\_\_\_\_

I understand that massage practitioners are not trained in the diagnosis and treatment of diseases. I confirm that I have consulted a medical doctor for all the conditions checked and have received authorization to have a massage. By signing this release, I do hereby waive and release the massage practitioner from all liability, past, present and future.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_