



**Life Balance  
Therapeutic  
Massage**



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## CLIENT HISTORY

*Please Print*

Date \_\_\_\_\_

Name \_\_\_\_\_ Birthday \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell # \_\_\_\_\_ Work # \_\_\_\_\_ Home # \_\_\_\_\_

Occupation \_\_\_\_\_ Email \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

PLEASE TAKE A MOMENT TO CAREFULLY READ THE FOLLOWING INFORMATION AND SIGN WHERE INDICATED.

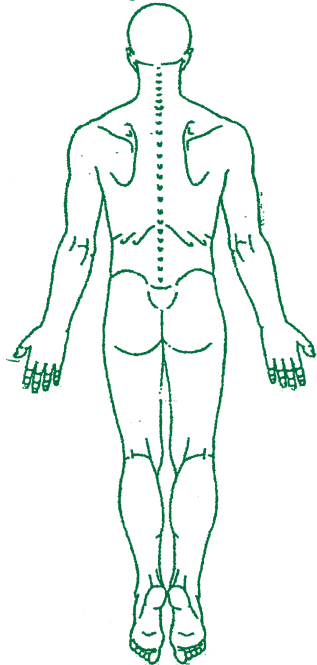
Missed appointments that are not cancelled at least 24 hours ahead of the scheduled time may be billed at 50% of the standard rate.

If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided. I understand that the massage, bodywork I receive is provided for the basic purpose of relaxation and the relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/body work practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so. It is also understood that any illicit or sexually suggestive remarks or advances made will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Practitioner Signature \_\_\_\_\_ Date \_\_\_\_\_

Please complete both sides

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