2011 1st Ave N, Saint Petersburg FL 33713
727-914-7318
(Bus. Lic # MA 35393)
handcraftedhealing@outlook.com
HealingStPete.com

DOWNLOAD OUR APP!

I, (legal name)_____, (client) understand that massage therapy provided at Handcrafted Healing LLC is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation, and offer a positive experience of touch.

I understand that if I am receiving Cupping Therapy there is a chance that a "mark" could be left in the area where cupping is performed and may be present for several days.

I have informed the massage therapist of all my known physical conditions, medical conditions and medication and will keep the therapist updated on any changes. I also understand that massage should not be a substitute for medical treatment or medications, and it is recommended that I continue to work with my PCP for any conditions I may have.

I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications and that spinal manipulations are not a part of massage therapy. I also understand that the Licensed Massage Therapist reserves the right to refuse or terminate the massage session to anyone whom she/he considers to have a condition which massage is contraindicated. I also understand that any illicit or inappropriate remarks/advances made by me will result in immediate termination of the session.

First & Last Name: _____ DOB: _____ Age: _____

Preferred Pronoun:___She/Her____He/Him____They/Them Phone:_____

Address:_____ City/State/Zip:_____

Email:_____ Occupation:_____

How did you hear about us?_____Activity Level (1-10)_____

Have you had professional massage before?_____When was your last?_____

Pressure Preference: light medium deep

Any allergies (scent, food, herb,nut)? _____

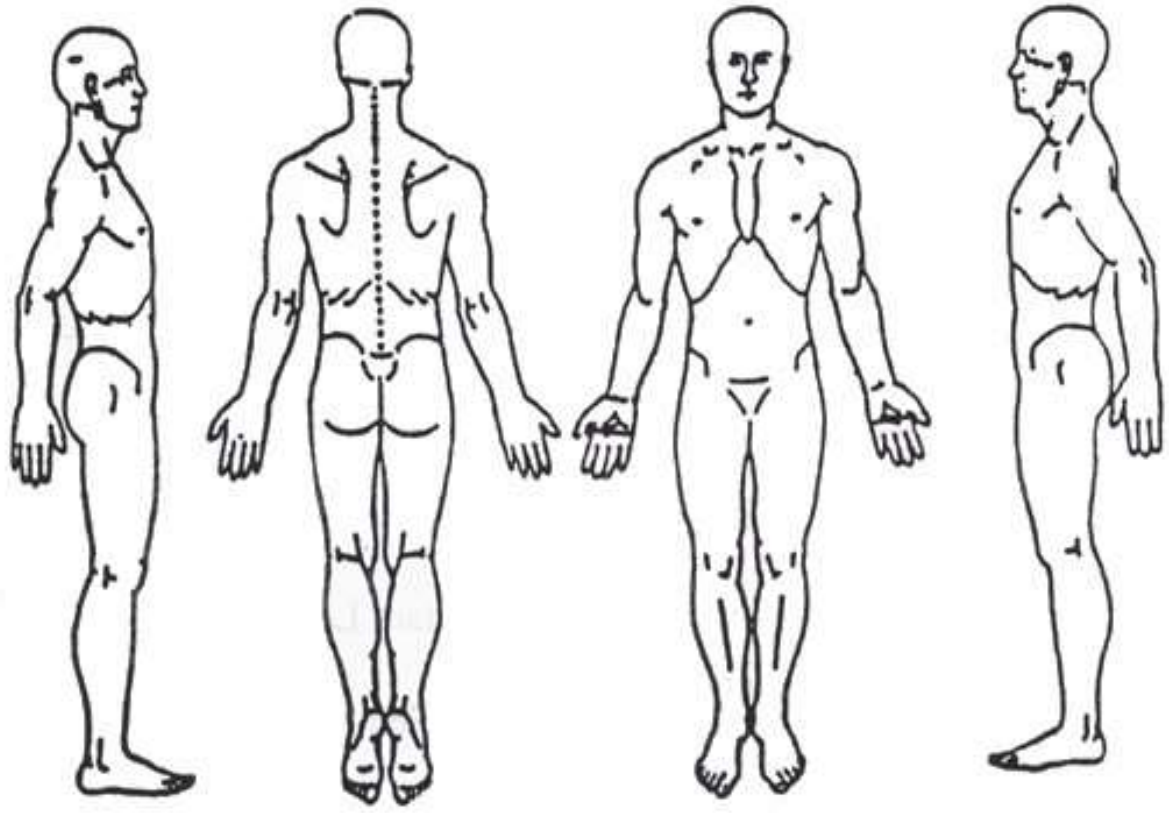
Are you currently under a physicians care or on medications? **(Y N)**
Explain:_____
Any accidents, health issues or surgeries in the last year? **(Y N)**
Explain:_____

_____

Please review and check conditions that have affected your health either recently or in the past.

Arthritis _____	Bursitis _____	Tendonitis _____	Diverticulitis _____
Blood clots _____	Bruise easily _____	Broken Bones _____	Dislocations _____
Cancer_____	Chronic Pain _____	Digestion Issues _____	Blood Pressure _____
Liver Disease _____	Skin Conditions _____	TMJ_____	Heart Issues _____
Auto-Immune Disease _____	**Surgeries** _____		Stroke _____
Depression _____	Anxiety _____	Panic disorder _____	Headaches _____
Migraines _____	**Pregnancy** (separate form)	Back Problems _____	
Insomnia _____	Seizures _____	Whiplash_____	Scoliosis _____
Chemical dependency (alcohol, drugs, pain meds) _____			**COVID-19**_____

Additional Info:_____



PLEASE CIRCLE AREAS OF DISCOMFORT

Emergency Contact:_____Relationship:_____Ph:_____

Please Sign: _____ Date:_____

Therapist signature: _____