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Client Contact Information

Client Name:_____Date: _____

Date of Birth: Age: _____ Male ☐ Female ☐

Address:_____

Preferred Phone:_____Email:_____

What's your occupation?_____

Referred by:_____No Referral ☐

Emergency contact:_____Phone:_____

Relationship: _____

Physician/Health-care Provider name:_____Phone: _____

Is this massage/bodywork medically necessary (Is it for a medical condition, injury, surgery)? Yes ☐ No ☐

Do you have a physician referral/prescription? Yes ☐ No ☐

Massage Information

Have you ever received professional massage/bodywork before? Yes ☐ No ☐

How recently? _____

What types of massage/bodywork do you prefer? _____

What kind of pressure do you prefer? Light ☐ Medium ☐ Firm ☐ It Depends ☐

If "It Depends", please explain: _____

What are your goals/expected outcomes for receiving massage/bodywork?

_____

How do you feel today? _____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

_____

_____

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes ☐ No ☐

Please Explain: _____

_____

List medications you currently take & the condition you take it for; Please list supplements as well:

_____

_____

_____

_____

_____

Do you wear contacts? Yes ☐ No ☐ Do you wear dentures or dental prosthetics? Yes ☐ No ☐

Do you take blood thinners/fish oil? Yes ☐ No ☐ Do you wear a hairpiece? Yes ☐ No ☐ Are you pregnant? Yes ☐ No ☐

Taken Antibiotics in the last 2 weeks? Yes ☐ No ☐ Had a Cold or Flu in last 2 weeks? Yes ☐ No ☐

Have you had any injuries or surgeries in the past that may influence today's treatment?

_____

Circle any of the following health conditions that you currently have *(If you are unsure, please ask)*:

blood clots infections congestive heart failure contagious diseases pitted edema

*Please answer honestly. For your health and safety, massage **may not** be indicated for the above conditions*

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Client Name:_____DOB: _____

Health History

Please indicate conditions, surgeries or injuries that you currently have or have had in the past.

Explain & Date as appropriate, including treatment received:

☐ Current ☐ Past Muscle or joint pain _____

☐ Current ☐ Past Muscle or joint stiffness _____

☐ Current ☐ Past Numbness or tingling _____

☐ Current ☐ Past Swelling _____

☐ Current ☐ Past Bruise easily _____

☐ Current ☐ Past Sensitive to touch/pressure _____

☐ Current ☐ Past High/Low blood pressure _____

☐ Current ☐ Past Stroke, heart attack _____

☐ Current ☐ Past Varicose veins _____

☐ Current ☐ Past Shortness of breath, asthma _____

☐ Current ☐ Past Cancer _____

☐ Current ☐ Past Neurological (e.g. MS, Parkinson's, chronic pain) _____

☐ Current ☐ Past Epilepsy, seizures _____

☐ Current ☐ Past Headaches, Migraines _____

☐ Current ☐ Past Dizziness, ringing in the ears _____

☐ Current ☐ Past Digestive conditions (e.g. Crohn's, IBS) _____

☐ Current ☐ Past Gas, bloating, constipation _____

☐ Current ☐ Past Kidney disease, infection _____

☐ Current ☐ Past Arthritis (rheumatoid, osteoarthritis) _____

☐ Current ☐ Past Osteoporosis, degenerative spine/disk _____

☐ Current ☐ Past Scoliosis _____

☐ Current ☐ Past Broken bones _____

☐ Current ☐ Past Allergies _____

☐ Current ☐ Past Diabetes _____

☐ Current ☐ Past Endocrine/thyroid conditions _____

☐ Current ☐ Past Depression, anxiety _____

☐ Current ☐ Past Memory Loss, confusion, easily overwhelmed _____

Comments:

_____

Consent for Treatment

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/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork 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 medical 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 fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature:_____Date: _____

Parent or Guardian Signature *(in the event client is a minor)*:_____Date: _____