Health Information

Client Name: _____ Clinic Phone Number: _____

Date of Birth: _____ Client Phone Number: _____

Address: _____ Email Address: _____

Emergency Contact: _____ Emergency Phone Number: _____

Physician/Health Care Provider Name: _____

Do you have a physician referral/prescription? ○ YES ○ NO

Are you seeking insurance reimbursement? ○ YES ○ NO
If 'Yes', please see *Release of Information* form

Massage Information

Have you ever received professional massage/bodywork before? ○ YES ○ NO

If 'YES', how recently? _____

What types of massage/bodywork do you prefer?
- ○ Relaxation/Swedish
- ○ Muscle Energy Technique
- ○ Chair Massage

Have you ever trialed any add-on services before?
- ○ Aromatherapy
- ○ Cupping
- ○ Graston Technique
- ○ Hot Stone
- ○ Paraffins

What kind of pressure do you prefer? ○ Light ○ Medium ○ Firm

What are your goals/expected outcomes of 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 daily living [sleep, exercise, work, childcare] ○ YES ○ NO

List any current medications you are taking: _____

_____

Are you pregnant? ○ YES ○ NO If 'YES', how many weeks? _____
Are you wearing contacts? ○ YES ○ NO
Are you wearing dentures? ○ YES ○ NO
Have you had any injuries or surgeries in the past that may influence today's treatment? ○ YES ○ NO

List any surgeries: _____

Do you currently have any of the following:

- ○ Blood Clots
- ○ Infections
- ○ Congestive Heart Failure
- ○ Contagious disease
- ○ Pitting Edema

**Please note, if you currently are experiencing any of the above conditions, you may not be able to receive massage/bodywork services today as they may cause you more harm. Your massage therapist may be able to discuss referrals or other treatment options.

Do you experience any of the following:

- ○ Muscle or Joint Pain
- ○ Muscle or Joint Stiffness
- ○ Numbness or Tingling
- ○ Swelling
- ○ Bruise Easily
- ○ Sensitive to Touch/Pressure
- ○ High/Low Blood Pressure
- ○ Stroke/Heart Attack
- ○ Varicose Veins
- ○ Shortness of Breath/Asthma
- ○ Cancer
- ○ Neurological [MS/Parkinson's/ Chronic Pain]
- ○ Epilepsy/Seizures
- ○ Endocrine/Thyroid Conditions
- ○ Headaches/Migraines
- ○ Dizziness/Ringing in the Ears
- ○ Digestive Conditions [Crohn's, IBS, Colitis]
- ○ Gas/Bloating/Constipation
- ○ Kidney Disease/Infection
- ○ Osteoporosis/Degenerative Disc Disease
- ○ Scoliosis
- ○ Broken Bones
- ○ Allergies
- ○ Diabetes
- ○ Depression/Anxiety
- ○ Memory Loss/Confusion/Easily
- ○ Overwhelmed
- ○ Other_____

Consent for Treatment

Clients under the age of 18 must be accompanied by a legal guardian during the entire session. Informed written consent must be completed by legal guardian for any client under the age of 18 prior to service.

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 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. I agree that this release is in effect for all current and future sessions provided.

Client Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____