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# Confidential Client Information

## General Information

Name: _____ Occupation: _____ Date of Initial Visit: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Emergency Contact: _____ Home Phone: _____ Other Phone:_____

Health Insurance Carrier: _____ Male: _____ Female: _____

Have you ever received a Professional Massage? _____ When did you last receive bodywork? _____

What Type? _____What type of setting? _____Overall Impression of session? _____

How did you hear about my practice? _____

## Lifestyle Information

Have you consumed any alcohol in the past 24 – hours? _____ Please list your sleep positions: _____

Do you exercise? _____ How often? _____ What type? _____

Do you use tobacco? _____ Do you drink caffeine? _____ How much water do you drink daily? _____

On a scale of 1 – 10 (10 being the highest) what is you stress level? _____ Where do you hold tension in your body? _____

What are your goals for the first session? _____

## General Medical Information

Physician: _____ Physician's Phone: _____

Do you wear contact lenses? _____ Dentures? _____ Hearing aid? _____ Prosthetics? _____

Are you taking any medication? _____ List: _____

Are you currently under a Doctor's care? _____ If yes, please explain: _____

Are you Pregnant ? _____ Do I have permission to contact your Doctor should the need arise? _____

Do you have allergic reactions to any food, herbs or nuts? _____ List: _____

Do you bruise easily? _____ Any noticeable bruises today? _____

Please list any major surgeries or broken bones in the past 2 years? _____

Any sprains of muscle joint injuries in the past 2 years? If yes, please explain: _____

Are you sensitive to touch in any specific area? If yes, please list: _____

Have you recently been involved in any type of injury or accident? If yes, please explain: _____

_____

## Please check all that apply and explain in detail in space provided below:

___ Diabetes
___ Arthritis
___ High blood pressure
___ Allergies
___ Varicose veins
___ Osteoporosis
___ Circulatory problems
___ Back pain
___ Neck pain
___ Numbness
___ Whiplash
___ Joint ache
___ Broken bones
___ Decreased range of motion
___ Sciatica
___ Headaches
___ Shoulder pain
___ Sprains
___ Seizures
___ Abdominal pain
___ Nervous tension
___ Depression
___ Bursitis
___ Scoliosis
___ Carpal Tunnel Syndrome
___ HIV
___ Breast augmentation
___ Sinus conditions
___ Mastectomy
___ Colitis
___ Stroke
___ Heart attack
___ Cancer
___ Asthma
___ Chronic Fatigue Syndrome
___ Herpes I or II
___ Stomach ulcers
___ Hepatitis B or C
___ Menstrual problems
___ Implants
___ Epilepsy
___ Fluid retention
___ Herniated disc
___ Digestive problems
___ Fibromyalgia
___ Respiratory conditions
___ Other

Please detail ALL items checked:
_____
_____
_____
_____
_____
_____
_____

## Do you have any of the following today?

___ Sunburn
___ Poison ivy
___ Irritated skin rash
___ Cold / Flu
___ Headache
___ Severe pain
___ Inflammation
___ Open cuts / bruises

Please detail ALL items checked: _____
_____
_____

## Please check areas in which you do **NOT** wish to receive bodywork:

___ Face ___ Neck ___ Scalp ___ Upper Back ___ Shoulders
___ Mid Back ___ Low Back ___ Upper Chest ___ Abdominals ___Arms
___ Hands ___ Feet ___ Lower Leg ___ Thigh ___ Gluteals
___ Other (list) _____

*Please take a moment to carefully read the following information and sign where indicated. If you have specific medical conditions or specific symptoms, massage / bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided. Failure to fully complete this information will result in not receiving services from this Registered Massage Practitioner or MD State Certified Massage Therapist.*

I understand that this massage is not a replacement for medical care and that no diagnosis will be made. I understand that the massage / bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. I understand that if I experience any pain or discomfort during the session, I will immediately inform the practitioner / therapist so that the pressure / stroke 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 / therapists are not qualified to perform spinal or skeletal adjustments, diagnosis, prescribe, or treat any mental or physical 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 / therapist updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's / therapist'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 full payment of the scheduled appointment.

Client Signature: _____ Date: _____

Practitioner /Therapist Signature: _____ Date: _____

Consent to Treatment of Minors: By my signature below, I hereby authorize _____ to administer massage / bodywork, or somatic therapy techniques to my child or dependant as they deem necessary.

Signature of parent or guardian: _____ Date: _____