CLIENT INFORMATION

Name | Telephone [ ] | Date of Birth

Address | E-mail

Referred by | Telephone [ ]

In case of emergency | Telephone [ ]

GENERAL & MEDICAL INFORMATION

Age | Male | Female

Yes No Do you have Type I diabetes?
Yes No Do you have Type II diabetes?
Yes No Do you experience frequent headaches?
If yes to previous question, how often? ______
Yes No Do you suspect that these headaches are hormone related?
Yes No Are you 0 - 8 weeks post partum?
Yes No Are you pregnant? If yes, how many weeks? ______
Yes No Do you suffer from arthritis? Osteo or rheumatoid?
Yes No Are you wearing contact lenses?
Yes No Do you have high blood pressure?
Yes No If *yes* to previous question, are you taking medication for this?
Yes No Do you suffer from epilepsy or seizures?
Yes No Do you suffer from joint swelling?
Yes No Do you have varicose veins?
Yes No Have you had major surgery in the last 2 years?
Yes No Do you have any contagious diseases?
Yes No Do you have osteoporosis or osteopenia?
Yes No Do you bruise easily?
Yes No Have you had any broken bones in the past two years?
Yes No Have you been in an accident or suffered any injuries in the past two years?
Yes No Do you have trouble turning your head left or right?
Yes No Have you been extremely sedentary in the last 48 hours? (For example, flew from Asia.)
Yes No Do you have tension or soreness in a specific area?

Yes No Do you have cardiac or circulatory problems?
Yes No Do you suffer from back pain?
Yes No Do you have numbness or stabbing pains anywhere?
Yes No Are you very sensitive to touch or pressure in any area?
Yes No Do you take blood thinners?
Yes No Do you have limited range of motion in any body part?
Yes No Do you have any herniated discs in your spine? If yes, please indicate the age of the injury: ___________
Yes No Do you have any other medical condition I should be aware of?

Comments:____

Please take a moment to carefully read the following information and sign where indicated. 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 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 or 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 specialists for any mental or physical ailment that I am aware of. 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 forget to do so. It is also understood 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.

Client Signature | Date

Practitioner Signature | Date

Consent to Treatment of Minor: By my signature below, I hereby authorize ______________________ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian | Date