

Please complete this form completely and to the best of your ability.

Personal Information:

Patient Name: _____ Date: _____
 Date of Birth: _____ Age: _____ Sex: M F Marital Status: S M D
 Address: _____ City: _____
 State: _____ Zip: _____ *E-mail: _____
 Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____
 Emergency Contact: _____ Relationship: _____ Phone #: _____

Wellness Information:

Have you ever had a professional massage or bodywork? Yes No If so, when? _____
 Have you received Chiropractic care? Yes No Are you currently under Chiropractic Care? Yes No
 Do you take time to relax? Yes No Do you feel you are under stress? Yes No
 What goals / benefits do you wish to achieve from massage therapy? _____
 Are you currently physically active? Yes No What activities & how often? _____

Injury History:

Auto Accident/Year(s): _____ Injury at Work/Year(s): _____ Fall or Other Injury/Year(s): _____ Sports Injury/Year(s): _____
 Please describe any injuries / conditions: _____
 How long has this condition existed? _____ Have you had this condition in the past? _____

Programs:

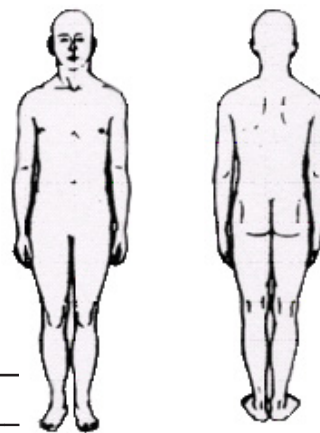
Are you enrolled in a Federally Funded Insurance Program? Yes No

Medical Information:

Are you currently taking medication? Yes No Types: _____
 Do you have any allergies? Yes No Please List: _____
 Are you currently under the care of a physician, physical therapist, or psychologist? Yes No If so, Why? _____

Please check all conditions that apply & mark areas you would like addressed on the diagrams: Please Mark Below:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arteriosclerosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Athlete's foot | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Burns | <input type="checkbox"/> Cancer/Tumors |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Cuts or Sores |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fractures | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Joint Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Paralyzes | <input type="checkbox"/> Plates / Screws | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Spinal Problems |



How did you hear about our Massage Therapists? _____

I understand that a massage therapist provides the massage/bodywork I receive for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes will be adjusted to my level of comfort. I further understand that massage and 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 session 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 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 practitioners 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. Lastly, I authorize instructor observation and demonstration of techniques if so warranted.

Client Signature: _____ Date: _____

Consent to Treatment of Minor: My signature below hereby authorizes a Certified Massage Therapist to administer massage, bodywork or somatic therapy techniques to my child or dependent, as they deem necessary.

Signature of Parent or Guardian: _____ Date: _____