HEALTH SCREEN, MEDICAL INFORMATION, & CLIENT AUTHORIZATION

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____ (WE PROMISE NOT TO SPAM YOU!)

PRIMARY PHONE (PLEASE CIRCLE: MOBILE/HOME/WORK): _____

SECONDARY PHONE (PLEASE CIRCLE: MOBILE/HOME/WORK): _____

IF WE NEED TO CALL YOU ABOUT AN APPOINTMENT, IS IT OKAY FOR US TO LEAVE A MESSAGE? _____

HOW DID YOU HEAR ABOUT US? _____
(IF YOU HEARD ABOUT US FROM ANOTHER CLIENT, PLEASE NAME THEM SO WE CAN REWARD FOR THE REFERRAL!)

WHEN (IF EVER) WAS YOUR LAST MASSAGE? _____

WHAT ARE YOUR GOALS FOR MASSAGE?

_____ RELAXATION
_____ INJURY REHABILITATION/PAIN RELIEF
_____ HIGH ACTIVITY LEVEL, MAINTENANCE MASSAGE
_____ OTHER: _____

HOW MANY HOURS A WEEK WOULD YOU ESTIMATE YOU SPEND DOING SERIOUS PHYSICAL ACTIVITY OR SPORTS? _____

WHAT IS YOUR PROFESSION? _____

PLEASE LIST ANY ALLERGIES: _____

PLEASE LIST ANY MEDICATIONS AND THEIR PURPOSE: _____

_____

IS THERE ANY CHANCE YOU ARE PREGNANT? _____

DO YOU HAVE ANY OF THE FOLLOWING TODAY?

_____ SUNBURN
_____ INFLAMMATION
_____ SEVERE PAIN
_____ HEADACHE
_____ NEUROPATHY/NUMBNESS
_____ CUTS, BURNS, BRUISES
_____ IRRITATED SKIN RASH
_____ POISON IVY
_____ COLD OR FLU

FORM CONTINUES ON NEXT PAGE

HAVE YOU EVER HAD ANY OF THE FOLLOWING?:

_____ BLOOD CLOT (DVT)/VARICOSE VEINS/OTHER CIRCULATORY ISSUE
_____ HERNIATED (RUPTURED) OR BULGING DISK
_____ SKIN CONDITION/SKIN SENSITIVITY
_____ DIABETES
_____ HIGH/LOW BLOOD PRESSURE
_____ CHEMOTHERAPY OR RADIATION (DATE:_____)
_____ CORTISONE INJECTION (LOCATION/DATE:_____)
_____ TENDONITIS (LOCATION/DATE:_____)
_____ IMPLANTS (PACEMAKER, ARTIFICIAL JOINTS, HAIR, BREAST, NORPLANT, ETC.)
_____ DISLOCATED JOINTS OR JOINT SPRAINS (LOCATION/DATE:_____)
_____ BONE FRACTURES (LOCATION/DATE:_____)
_____ SURGERY (REASON/DATE:_____)

ANY OTHER CONDITIONS WE SHOULD BE AWARE OF, OR ANYTHING ELSE YOU'D LIKE US TO KNOW:

_____

_____

_____

_____

_____

READ AND INITIAL THE FOLLOWING, AND SIGN BELOW:

_____ I AM RESPONSIBLE FOR PAYING FOR ANY CANCELLATION OF LESS THAN 24-HOURS.

_____ THE THERAPIST HAS THE RIGHT TO END THE SESSION OR REFUSE SERVICE AT ANY TIME, FOR ANY REASON.

_____ IF I AM UNCOMFORTABLE FOR ANY REASON, I MAY ASK FOR THE MASSAGE TO CEASE AND THE THERAPIST WILL END THE SESSION IMMEDIATELY.

_____ I HAVE DISCLOSED ANY CONDITION I HAVE THAT WOULD CONTRAINDICATE MASSAGE.

_____ I UNDERSTAND THAT MASSAGE IS NOT A REPLACEMENT FOR MEDICAL CARE, AND THAT MASSAGE THERAPISTS DO NOT DIAGNOSE CONDITIONS, PERFORM SPINAL MANIPULATIONS, OR PRESCRIBE MEDICAL TREATMENTS.

SIGNATURE: _____ DATE: _____