

Practitioner/Clinic Name: \_\_\_\_\_

## Health Information

Contact Information: \_\_\_\_\_

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### Client Contact Information

Client Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Referred by: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician/Health-care Provider name: \_\_\_\_\_ Phone: \_\_\_\_\_

Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes  No

Do you have a physician referral/prescription? Yes  No

Are you seeking insurance reimbursement? Yes  No  If yes, please complete the Billing Information form.

Type of insurance coverage for this claim: Car Collision    Worker's Compensation    Private Health

### Massage Information

Have you ever received professional massage/bodywork before? Yes  No

How recently? \_\_\_\_\_

What types of massage/bodywork do you prefer? \_\_\_\_\_

What kind of pressure do you prefer?    Light                      Medium                      Firm

What are your goals/expected outcomes for 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 activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No  
Explain:

\_\_\_\_\_  
\_\_\_\_\_

List the medications you currently take:

\_\_\_\_\_  
\_\_\_\_\_

Are you wearing contacts?    Yes  No

Are you wearing dentures?    Yes  No

Are you wearing a hairpiece?    Yes  No

Are you pregnant?    Yes  No

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### Health History

Have you had any injuries or surgeries in the past that may influence today's treatment?

Circle any of the following health conditions that you currently have (If you are unsure, please ask):

blood clots, infections, congestive heart failure, contagious diseases, pitted edema

Please answer honestly, as massage may not be indicated for the above conditions.

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

- |         |      |                                                   |       |
|---------|------|---------------------------------------------------|-------|
| Current | Past | Muscle or joint pain                              | _____ |
| Current | Past | Muscle or joint stiffness                         | _____ |
| Current | Past | Numbness or tingling                              | _____ |
| Current | Past | Swelling                                          | _____ |
| Current | Past | Bruise easily                                     | _____ |
| Current | Past | Sensitive to touch/pressure                       | _____ |
| Current | Past | High/Low blood pressure                           | _____ |
| Current | Past | Stroke, heart attack                              | _____ |
| Current | Past | Varicose veins                                    | _____ |
| Current | Past | Shortness of breath, asthma                       | _____ |
| Current | Past | Cancer                                            | _____ |
| Current | Past | Neurological (e.g. MS, Parkinson's, chronic pain) | _____ |
| Current | Past | Epilepsy, seizures                                | _____ |
| Current | Past | Headaches, Migraines                              | _____ |
| Current | Past | Dizziness, ringing in the ears                    | _____ |
| Current | Past | Digestive conditions (e.g. Crohn's, IBS)          | _____ |
| Current | Past | Gas, bloating, constipation                       | _____ |
| Current | Past | Kidney disease, infection                         | _____ |
| Current | Past | Arthritis (rheumatoid, osteoarthritis)            | _____ |
| Current | Past | Osteoporosis, degenerative spine/disk             | _____ |
| Current | Past | Scoliosis                                         | _____ |
| Current | Past | Broken bones                                      | _____ |
| Current | Past | Allergies                                         | _____ |
| Current | Past | Diabetes                                          | _____ |
| Current | Past | Endocrine/thyroid conditions                      | _____ |
| Current | Past | Depression, anxiety                               | _____ |
| Current | Past | Memory Loss, confusion, easily overwhelmed        | _____ |

Comments:

### Consent for Treatment

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 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 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.

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent or Guardian Signature (in case of a minor): \_\_\_\_\_

Date: \_\_\_\_\_