

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: _____

