Client Information

New____ Updated____

Name:____Date of Birth:___________________

Preferred Nickname:________________________________ Phone (_________)__________________________

Address:____________________________________City_________________State________Zip______________

Email:____

Preferred method of communication: _____ *text* _____ *call* _____ *email* Bio Gender ______________

Occupation:_______________________________________Referred by:_____________________________

Emergency contact?__________________________________Phone: (_________)_________________________

Please take a moment to carefully read and answer the following questions. Certain medical conditions or specific symptoms may be incompatible with massage therapy or require altering the treatment to accommodate circumstances, so please be honest and thorough.

Have you ever experienced a professional massage or bodywork session? ____Yes _____No

Have you experienced any of the following symptoms in the past 72 Hours: fever over 100*, chills, new loss of taste/smell, nausea/vomiting, diarrhea, thick colored mucus, sudden onset of body aches/pains, or any other symptoms of a cold, flu, or other infectious condition? ___No ___Yes (please tell the therapist now, if so)

Have you sustained any particularly significant injuries in the past year? ___No ___Yes:_______________________

Are you currently pregnant or suspect it is possible at this time? ___No ___Yes: weeks:_________ _____Maybe

Are you currently recovering from a surgery, illness or injury? ___No Yes:__________________________________

Do you wear: _____ contacts _____ dentures _____ hearing aids ____ prosthetic:_____________________

Please list any surgeries you have had in the past six months, **or** for which you still experience issues, had a body part(s) removed or where you had permanent hardware installed, and the year it was done:

____

____

____

Please list any other major tests or procedures you have had done in the last six months:

____

____

____

Please list your current medications (prescribed or OTC) as accurately as possible. Supplements are not necessary unless you are dosing medicinally. You may continue on the back of the page if needed. Check here if so:______

Name *Reason* *Daily or As needed*

____

____

____

____

____

____

please continue on the next page…

L = Left side
R = Right side
B = Both sides

Put a check mark next to any of the following symptoms or conditions which currently or often apply to you:

_____High Stress
_____Neck pain/stiffness/aches L R B
_____Shoulder pain/stiffness/aches L R B
_____Upper back pain/stiffness/aches L R B
_____Lower back pain/stiffness/aches L R B
_____Hip pain/stiffness/aches L R B
_____Leg or Knee pain/stiff/aches L R B
_____Foot or Ankle pain/stiff/aches L R B
_____Hand or wrist pain/stiff/aches L R B
_____Allergies: Seasonal Topical Other:
____
____
____
_____Asthma or respiratory issues
_____Anxiety / Depression / Panic attacks
_____Skin condition:______________________

_____Headaches: Stress / Migraines / Sinus / Other
_____Joint swelling
_____Bruise easily
_____Radiating pain, stabbing sensations
_____Numbness or tingling
_____Sensitive to pressure or touch
_____Arthritis
_____Osteoporosis/osteopenia
_____Diabetes
_____Low blood sugar/hypoglycemia
_____High blood pressure
_____Low blood pressure
_____Cardiac or circulatory issues
_____Abdominal pain or discomfort
_____Sensitivities related to trauma, PTSD, mental health
_____Sensory issues

Please indicate any other diagnosed medical conditions or symptoms here that have not already been addressed or that you feel need to be explained or elaborated:
____
____
____

Please read carefully: This information will be used to tailor the treatment given to you as best as possible. **By signing below, you indicate that you have answered as fully and honestly as you could, and have read this paragraph carefully.** You understand that massage therapy and bodywork is provided primarily for the basic purpose of relieving discomfort and promoting relaxation and wellness. If you experience any pain or discomfort during the session, you will immediately notify the therapist so that the treatment can be adjusted to your level of comfort. You understand that at no time will *any* sexually inappropriate speech or action be tolerated, and any such remarks or advances will result in the immediate termination of the session. You understand that neither massage therapy nor bodywork of any kind should be construed as a substitute for appropriate medical examination, diagnosis or care. Massage therapists do not diagnose illness, perform spinal manipulations or adjustments, or prescribe medications. You understand that, because massage therapy involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of transmission of infectious illnesses such as colds, influenza or Covid-19. You understand that all reasonable precautions have been taken to provide you with a clean, disinfected space and materials, as outlined in the posted information on the website and in the treatment room. You acknowledge these risks and limitations, and consent to receive massage therapy and/or bodywork from this practitioner. ***Thank you***

X____ ___________________________
Client Signature or Guardian Signature if client is a minor or ward Date

X____ ___________________________
Printed name of Guardian if client is a minor or ward Relation to Client

Therapist Notes:
____
____
____ LMT Rvwd: