

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

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: _____