General Information

Client Contact Information

First name *

Enter your first name

Last name *

Enter your last name

Phone Number *

(___) ___-____

Email *

example@example.com

Birth date *

Select month

Select day

Select year

Street address

Enter street address

City

Enter city

State

Enter state

Zip code

Enter zip code

Emergency Contact Information

Contact Name

Phone Number

Doctor Contact Information (optional)

Doctor's Name

Phone Number

How did you hear about us?

Health Conditions and History

COVID-19 SYMPTOMS

Please check the box below if any of the following are true:

- •Have had a fever within the last 24 hours
- •Recently experienced respiratory/flu symptoms, sore throat, or shortness of breath
- •Contact, within the last 14 days, with anyone diagnosed with COVID or related symptoms

- [ ] COVID Symptoms Questionnaire

Minor Release form

Are you under 18? If so, please let me know through message, so that I can send over a form for your parent or guardian to sign.

Alcohol Consumption *

Have you had any alcoholic beverages in the last 24 hours? If so, that may lead to needing a driver to take you home after session or a reschedule.

RESPIRATORY

- [ ] Asthma
- [ ] Shortness of Breath
- [ ] Bronchitis
- [ ] Chronic Cough
- [ ] Emphysema

Anything not listed, please write here.

CARDIOVASCULAR

- [ ] Blood Clots
- [ ] Cold Hands
- [ ] High Blood Pressure
- [ ] Pacemaker
- [ ] Varicose Veins
- [ ] Cardiovascular Accident
- [ ] Congestive Heart Failure
- [ ] Low Blood Pressure
- [ ] Phlebitis
- [ ] Cerebral-vascular Accident
- [ ] Heart Attack
- [ ] Stroke

- [ ] Lymphedema
- [ ] Cold Feet
- [ ] Heart Disease
- [ ] Thrombosis/Embolism
- [ ] Myocardial Infarction

Anything not listed, please write here.

SKIN

- [ ] Bruise Easily
- [ ] Skin Irritations
- [ ] Hypersensitive Reaction
- [ ] Melanoma
- [ ] Skin Conditions

Scars or body modifications *

Please list all surgery, replacement body parts, or other modifications you have done to your body.

Anything not listed, please write here.

HEAD & NECK

- [ ] Ear Problems
- [ ] Hearing Loss
- [ ] Sinus Problems
- [ ] Vision Problems
- [ ] Vision Loss
- [ ] Migraines
- [ ] Headaches
- [ ] Jaw Pain (TMJD)

Anything not listed, please write here.

INFECTIOUS CONDITIONS

- [ ] Athlete's Foot
- [ ] Respiratory Conditions
- [ ] Hepatitis
- [ ] Skin Conditions
- [ ] HIV
- [ ] Herpes

Anything not listed, please write here.

REPRODUCTIVE

- [ ] Pregnancy
- [ ] Gynecological Issues

Anything not listed, please write here.

FAMILY HISTORY

- [ ] Cardiovascular Conditions
- [ ] Respiratory Conditions
- [ ] Cancer

Anything not listed, please write here.

NEUROLOGICAL

- [ ] Burning
- [ ] Numbness
- [ ] Tingling
- [ ] Stabbing Pain
- [ ] Cerebral Palsy
- [ ] Parkinsons
- [ ] Multiple Sclerosis
- [ ] Herniated Disc

Anything not listed, please write here.

MISCELLANEOUS

- [ ] Allergies
- [ ] Cancer
- [ ] Dizziness
- [ ] Hemophilia
- [ ] Mental Illness
- [ ] Surgical Pins or Wire
- [ ] Anaphylaxis
- [ ] Crohn's Disease
- [ ] Epilepsy

- [ ] Arthritis
- [ ] Osteoarthritis
- [ ] Rheumatoid Arthritis
- [ ] Artificial Joints/Special Equipment
- [ ] Diabetes
- [ ] Fibromyalgia
- [ ] Loss of Sensation
- [ ] Osteoporosis
- [ ] Shingles
- [ ] Stress
- [ ] Digestive Conditions
- [ ] Insomnia
- [ ] Gout
- [ ] Lupus
- [ ] Other Diagnosed Diseases
- [ ] Other Medical Conditions

Anything not listed, please write here.

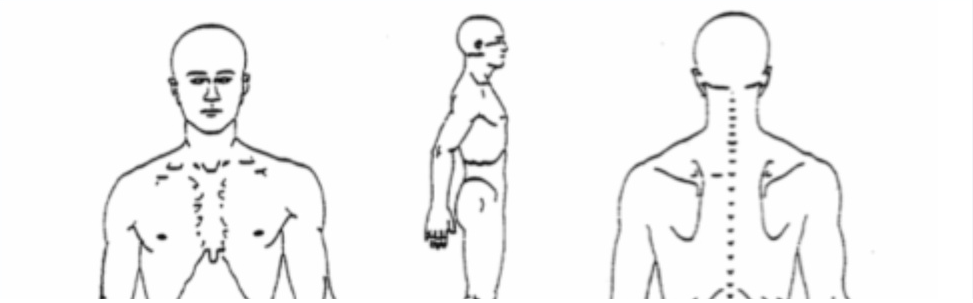
Allergies and other conditions your provider should be aware of

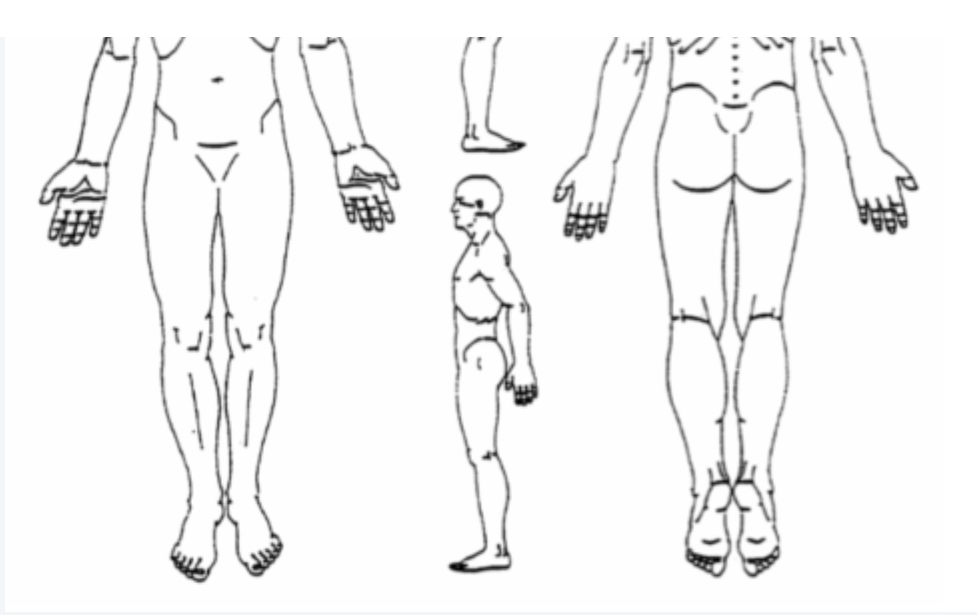
MEDICATIONS

Please list any medications, vitamins or drugs you are currently on. Needs to be updated due to legal reasons. ?

Issues to address

Click or tap the area(s) in question and describe sensation(s) i.e. tight, sharp pain, sore, bruising, dull ache, etc.





Cause of injury or concern ?

How long since first noticed ?

Treatment Goals ?

Past treatments ?

Signature page

Client Waiver Form

Please take a moment to read and initial the following information:

- I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.
- If I experience pain or discomfort during the session, I will ***immediately*** inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.
- I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.
- I affirm that I have notified my therapist of all known medical conditions and injuries.
- I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.
- I understand that massage is entirely therapeutic and non-sexual in nature.
- By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future, relating to massage therapy and bodywork.

Signature *

Sign above

I have read the statement above and agree to all the policies *

MM-DD-YYYY