NEW CLIENT FORM

Client Information

Name: _____ Birth Date_____/_____/_____

Address: _____ City/State/Zip: _____

Primary phone: _____ Secondary Phone_____

Email :_____(We don't share email)

How did you hear about us: Dr._____

Website_____ Other: (Please explain) _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Reason for today's visit? (I.e. Relieve discomfort, Manage pain, Maintain Health)

_____

Have you ever had a professional massage before? Yes___ No___
Are you pregnant or trying to get pregnant? Yes___ No___ If yes
How far along are you? _____

PLEASE MARK IF YOU HAVE/HAD ANY OF THE FOLLOWING CONDITIONS:

__Heart Conditions
__High Blood Pressure
__Vascular/Blood Disorders
__Skin Disorders
__Immune Disorders
__Stomach Disorders
__Diabetes
__Cancer
__Respiratory Disorders
__Arthritis
__Allergies
__Back or Chest Aches
__Broken Bones
__Headaches
__Neck/Shoulder Pain
__Sciatic Pain
__Leg/Foot Pain
__TMJ Syndrome
__Neuropathies
__ Edema
__Breast/Augmentation
__Dentures
__Wear Contacts
__Allergies to oils/scent_____
__Herniated/Bulging/Degenerative Discs
__Radiation / Chemotherapy treatment When? How long? _____

NEW CLIENT FORM

Do you Smoke? _____ Drink Alcohol? _____ Drink Caffeine? _____
Drink Soda? _____ Eat Chocolate? _____ Use lots of salt? _____
Exercise/ Stretching Habits? _____
How many times per week? _____ Duration? _____
Please advise us of any other health care professionals you have seen for this condition_____

Do you take any prescription medication? _____ If yes, please list:
_____

Do you have any **other** medical issues including past surgeries or injuries that I should be aware of before giving you massage therapy? If yes, please describe:
_____

Please read the following, initial and sign below:

___Be aware that our Licensed Massage Therapists have wide variety of Advanced Training. Techniques to be used include Myofascial Release, Trigger Point, Swedish gymnastics, Visceral manipulation, Manual Lymphatic drainage, Craniosacral, Cupping, Muscle Energy Techniques, Range of Motion, Stretching, KinesioTaping.

___ Body parts to be treated include face, neck, scalp, shoulders, arms, hands, back, buttocks, hip flexors, legs, and feet. Therapists may treat muscles of the chest and ribcage; however they do *not* engage in massage of breast tissue.

___ Our Massage Therapists utilize only conservative draping during our sessions. If I feel uncomfortable for any reason I may ask to end the session.

___ I understand that the Massage Therapist does not diagnose illness, disease, or any other physical or mental disorder, nor perform spinal adjustments. Massage therapy is not a substitute for medical examinations and/or diagnosis. It is recommended that I see a physician for any physical ailment that I might have. I understand that Massage Therapy given here is for the purpose of, but not limited to: Fulfilling a prescription of a treating physician for a medically necessary condition. For relief from muscular spasm or fascial tension. To improve circulation.

___Because a Massage Therapist must be aware of existing physical conditions; I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

___I will respect the time of my Massage Therapist(s) and other clients. I agree to come to my scheduled appointments promptly, barring any unforeseen emergency. I understand that if I cancel later than 4 hours prior to my appointment, I agree to pay HALF the cost of my appointment. If I NO SHOW, I agree to pay the FULL price of the appointment.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

PAIN ASSESSMENT

PATIENT NAME: _____ **DATE:** _____

1. **HISTORY OF PAIN / SYMPTOMS**
   Check the folowing symptoms that you have:
   - ☐ Back Pain
   - ☐ Neck Pain
   - ☐ Leg Pain
   - ☐ Tingling/Numbness in Leg
   - ☐ Arm Pain
   - ☐ Tingling/Numbness in Arm
   - ☐ Other

2. **WHEN DID SYMPTOMS BEGIN?** _____

3. **HAVE YOU EVER HAD THIS PAIN BEFORE?**
   ☐ No ☐ Yes - When? _____

4. **WHAT DIAGNOSTIC TESTS HAVE YOU HAD** (MRI, X-Ray, CT Scan, Etc.) **?**
   _____

5. **HAVE YOU EVER HAD SURGERY FOR THIS ISSUE?**
   ☐ No ☐ Yes - What and When? _____

6. **HAVE YOU HAD ANY OF THE FOLLOWING TREATMENTS FOR YOUR PAIN?**
   Injections: ☐ No ☐ Yes - Did it help? _____
   Physical Therapy: ☐ No ☐ Yes - Did it help? _____
   What type of Therapy? _____

7. **WHAT MAKES YOUR PAIN BETTER?** _____

8. **WHAT MAKES YOUR PAIN WORSE?** _____

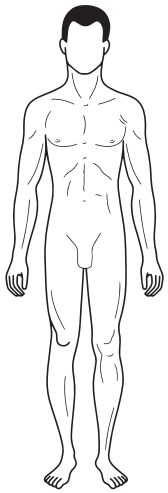
9. **DOES YOUR PAIN AFFECT ANY OF THE FOLLOWING?**
   - ☐ Movement
   - ☐ Sleep/Rest
   - ☐ Emotions
   - ☐ Activities - Explain: _____
   - ☐ Relationships
   - ☐ Concentration
   - ☐ Bowels
   - ☐ Bladder
   - ☐ Other - Explain: _____

10. **MEDICATIONS**
    Have you been taking any medications for your pain? _____
    _____
    Have you taken medication today: ☐ No ☐ Yes - What Medication? _____
    _____

PAIN ASSESSMENT

1. **PLACE AN X** at the location of your pain.
2. **CIRCLE THE LEVEL** of pain you experience.
3. **CIRCLE THE TYPE** of pain you are experiencing.

PAIN LEVEL
10
9
8
7
6
5
4
3
2
1
0



PAIN TYPE
Aching
Burning
Constant
Dull
Numbness
Sharp
Shooting
Stabbing
Tender
Throbbing
Tingling

PAIN LEVEL
10
9
8
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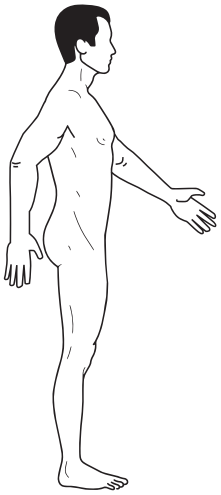

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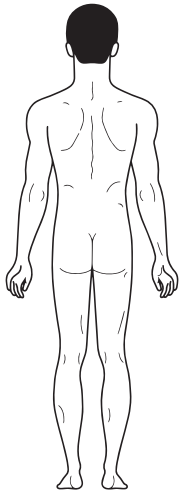

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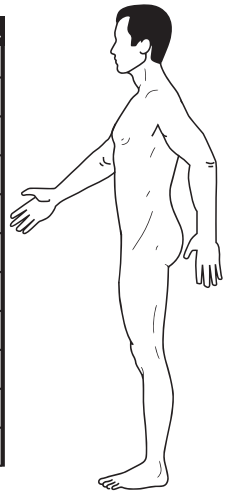

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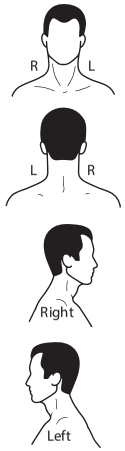

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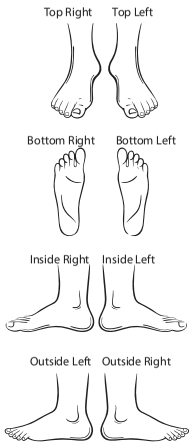

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