Client Information & Health Assessment Form

*Name:*_____ *Telephone:*_____
*Date of Birth:*_____ *Referred by:*_____
*Address:*_____
*E-Mail Address:*_____
*In case of emergency:*_____ *Telephone:*_____

General & Medical Information
Occupation:_____ Age:_____

Do you have health insurance: YES NO If yes, HMO or PPO Most insurances cover massages, would you like us to check your insurance benefits? YES NO (there is no charge or obligation)

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Please circle your response to the questions provided:

Have you ever experienced a professional massage or bodywork session? YES NO
If you answered YES, how recently?_____

If you circle "YES" to any of the following questions, please explain as clearly as possible.

YES NO Have you ever been diagnosed with a blood clot, deep vein thrombosis, or thrombophlebitis?
YES NO Do you frequently suffer from stress?
YES NO Do you have diabetes?
YES NO Do you experience frequent headaches?
YES NO Are you pregnant?
YES NO Do you suffer from arthritis?
YES NO Do you have high blood pressure?
YES NO Do you suffer from epilepsy or seizures?
YES NO Do you suffer from joint swelling?
YES NO Do you have varicose veins?
YES NO Do you have any contagious diseases?
YES NO Do you have any allergies?
YES NO Do you bruise easily?
YES NO Have you ever had surgery?
Please specify:_____
_____
_____

YES NO Have you had any broken bones in the past two years?
YES NO Have you been in an accident and suffered any injuries in the past two years?
YES NO Do you have tension or soreness in a specific area? Please specify:
_____
_____
YES NO Do you have cardiac or circulatory problems?
YES NO Do you suffer from back pain?
YES NO Do you have numbness or stabbing pains anywhere?
YES NO Are you very sensitive to touch or pressure in any area?
YES NO Do you have any other medical condition or are you taking any medications I should know about?
Comments:_____
_____
_____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. 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 or 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.

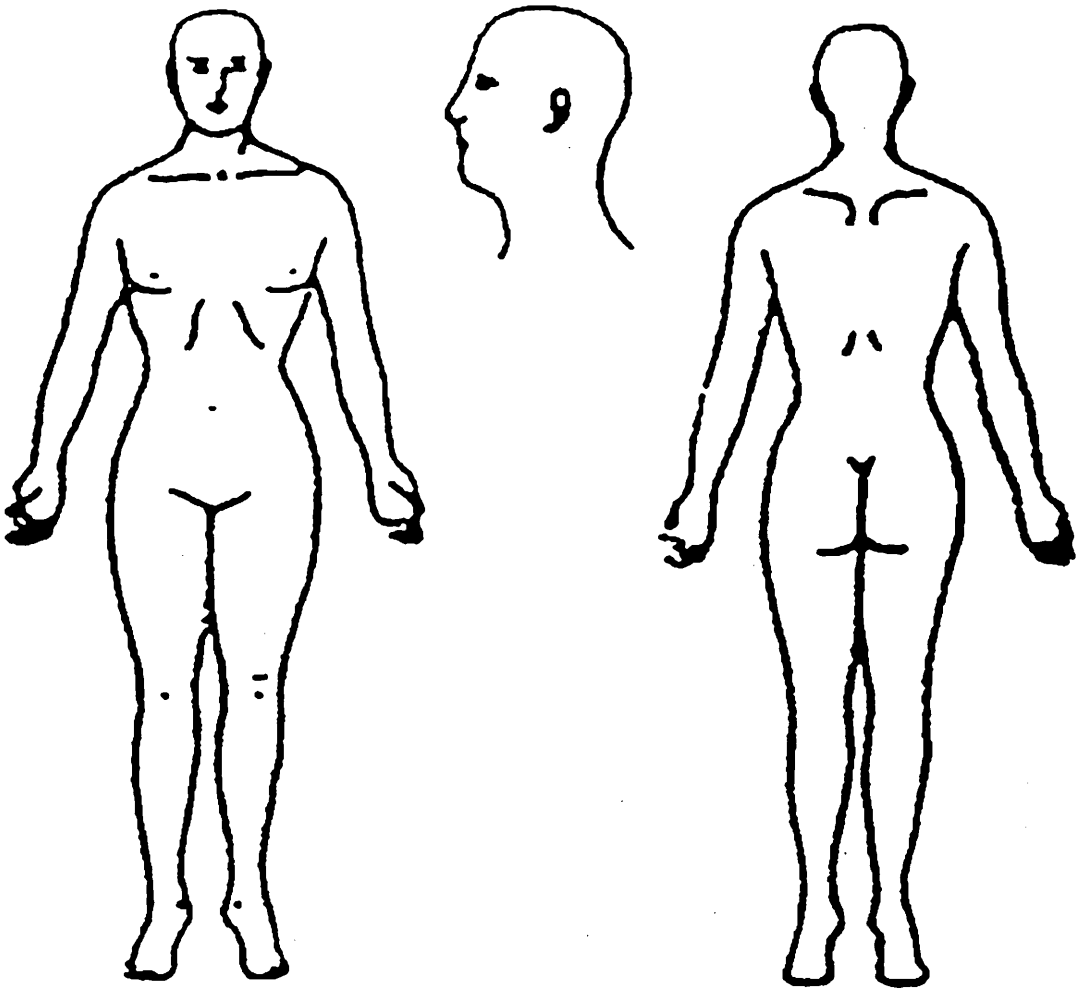
Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability 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.***

Client Signature:_____ Date:_____
Signature of Parent/Guardian:_____ Date:_____
Practitioner Signature:_____ Date:_____

Name _____ Date _____

Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

Aches ΛΛΛΛ Numbness oooo Pins/Needles ●●●● Burning xxxx Stabbing ////



Indicate the severity of your symptoms by marking an "X" on the lines below:

How bad are your symptoms now?

None Most Severe

How bad have they been in the past?

None Most Severe

Reference: Randsford. Spine, Vol. 1, No 2, June 1976