pain solutions

MEDICAL MASSAGE

Client Information

First Name | MI | Last Name

Date of Birth

Gender
- ◯ Male
- ◯ Female

If female, are you pregnant?
- ☐ Yes
- ☐ No

Address

City | State | Zip Code

Email | Phone

Occupation

Physician or Healthcare Provider | Phone

Emergency Contact | Phone

How did you hear about us?
- ☐ Google
- ☐ Facebook
- ☐ Yelp
- ☐ Groupon
- ☐ Word of Mouth
- ☐ Other

Treatment Information

What is your primary reason for your visit today?

Are you currently receiving treatment or training elsewhere? If so, please check all that apply.

- ☐ Physical Therapy
- ☐ Manual Therapy
- ☐ Aromatherapy
- ☐ Acupuncture
- ☐ Personal Training
- ☐ Hydrotherapy
- ☐ Chiropractic
- ☐ Yoga
- ☐ No other treatment or training.
- ☐ Other

Which of the following treatments are you interested in receiving?

- ☐ Massage Therapy
- ☐ Corrective Exercise
- ☐ Stretching
- ☐ Hydrotherapy
- ☐ Kinesiotaping

What is your current activity level?

- ☐ Little to no exercise every week.
- ☐ Moderate exercise every week.
- ☐ High intensity or high volume exercise every week.

Have you received a professional massage before?

- ◯ Yes
- ◯ No

How recently?

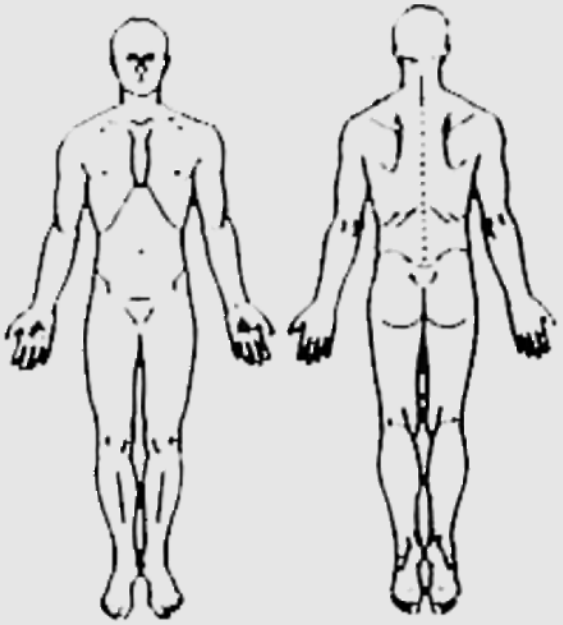
What kind of pressure do you prefer?

- ☐ Light
- ☐ Medium
- ☐ Firm

What are your goals for your corrective exercise or massage therapy treatments?

Special Considerations (if any):

Please indicate any areas of pain or discomfort using the pencil tool below:



Health Information

Have you had any injuries or surgeries that may influence your treatment? Please specify.

Please indicate if you have had a history of any of the following:

Blood Clots
- ◯ Yes
- ◯ No

Heart Disease
- ◯ Yes
- ◯ No

Stroke
- ◯ Yes
- ◯ No

Diabetes
- ◯ Yes
- ◯ No

Cancer
- ◯ Yes
- ◯ No

Seizures
- ◯ Yes
- ◯ No

Arthritis
- ◯ Yes
- ◯ No

High Blood Pressure
- ◯ Yes
- ◯ No

Low Blood Pressure
- ◯ Yes
- ◯ No

Asthma
- ◯ Yes
- ◯ No

Headaches/ Migraines
- ◯ Yes
- ◯ No

Shortness of Breath
- ◯ Yes
- ◯ No

Low Back Pain
- ◯ Yes
- ◯ No

Broken Bones/ Fractures
- ◯ Yes
- ◯ No

Dizziness/ Vertigo
- ◯ Yes
- ◯ No

Please list any medications you are currently taking.

Do you smoke?
- ☐ Tobacco - Rarely
- ☐ Tobacco - Moderately
- ☐ Tobacco - Frequently
- ☐ Medicinal - Rarely
- ☐ Medicinal - Moderately
- ☐ Medicinal - Frequently
- ☐ No.

Drink Caffeine?
- ☐ Less than a cup a day.
- ☐ A cup a day.
- ☐ More than a cup a day.
- ☐ No.

Do you have any allergies? Please specifiy.

Additional Comments:

Consent for Treatment

I understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician 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. 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 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. Understanding all of this, I give my consent to receive care.

Client Signature Date

Parent or Guardian Signature (if under 18) Date