

**CONFIDENTIAL INFORMATION**

WELCOME, WE WOULD LIKE TO MAKE YOUR MASSAGE OR MYOFASCIAL TRIGGER POINT THERAPY SESSION AS PLEASANT, EFFECTIVE AND COMFORTABLE AS POSSIBLE. PLEASE ASK ANY QUESTIONS THAT YOU MIGHT HAVE NOW OR AT ANY TIME IN THE FUTURE.

NAME \_\_\_\_\_ E-MAIL \_\_\_\_\_  
ADDRESS \_\_\_\_\_ STATE AND ZIP \_\_\_\_\_  
PRIMARY PHONE # \_\_\_\_\_ WORK OR OTHER # \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ GENDER \_\_\_\_\_  
REFERRED BY \_\_\_\_\_  
HAVE YOU EVER HAD A PROFESSIONAL MASSAGE BEFORE? \_\_\_\_\_ TRIGGER POINT THERAPY? \_\_\_\_\_  
SWEDISH \_\_\_\_\_ DEEP TISSUE \_\_\_\_\_ OTHER BODY WORK \_\_\_\_\_  
ARE YOU TAKING ANY MEDICATIONS? \_\_\_\_\_ WHAT AND WHY? \_\_\_\_\_

DO YOU HAVE A HISTORY OF OR BELIEVE YOU HAVE ANY OF THE FOLLOWING?

<input type="checkbox"/> <b>BLOOD CLOTS</b>	<input type="checkbox"/> neck pain	<input type="checkbox"/> allergy to massage lotions	Indicate heavy use of any of the following:
<input type="checkbox"/> <b>CALF PAIN</b>	<input type="checkbox"/> headaches	<input type="checkbox"/> allergy to oils body lotions	
<input type="checkbox"/> <b>ANTI-COAGULENT</b> (blood thinner meds)	<input type="checkbox"/> migraines	<input type="checkbox"/> allergy to perfume	
<input type="checkbox"/> pregnant now?	<input type="checkbox"/> shoulder pain	<input type="checkbox"/> any other allergy? Foods?	<input type="checkbox"/> Artificial Sweeten
<input type="checkbox"/> whiplash	<input type="checkbox"/> upper back pain	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> diet drinks/ foods
<input type="checkbox"/> seizures	<input type="checkbox"/> mid back pain	<input type="checkbox"/> arthritis or gout	<input type="checkbox"/> sugar
<input type="checkbox"/> stroke	<input type="checkbox"/> low back pain	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> caffeine
<input type="checkbox"/> cancer	<input type="checkbox"/> hip pain	<input type="checkbox"/> heart attack, cardiac problems	<input type="checkbox"/> tobacco
<input type="checkbox"/> diabetes	<input type="checkbox"/> leg pain or numbness	<input type="checkbox"/> skin disease or conditions	<input type="checkbox"/> alcohol
<input type="checkbox"/> surgery	<input type="checkbox"/> arm pain or numbness	<input type="checkbox"/> HIV / Hepatitis	<input type="checkbox"/> pain medications
<input type="checkbox"/> asthma	<input type="checkbox"/> hand pain or numbness	<input type="checkbox"/> varicose veins	<input type="checkbox"/> recreational drugs
<input type="checkbox"/> colitis/ IBS etc	<input type="checkbox"/> foot pain or numbness	<input type="checkbox"/> wear any prosthesis	<input type="checkbox"/> soda/pop
<input type="checkbox"/> bursitis	<input type="checkbox"/> bruising easily	<input type="checkbox"/> breast augmentation	<input type="checkbox"/> salt
<input type="checkbox"/> sprains (serious)	<input type="checkbox"/> high stress	<input type="checkbox"/> wear dentures	Do you get adequate amounts of:
<input type="checkbox"/> accidents	<input type="checkbox"/> extreme stiffness	<input type="checkbox"/> wear contact lenses	
	<input type="checkbox"/> recurring injury/pain	<input type="checkbox"/> broken bones	<input type="checkbox"/> exercise

Do you have any other medical condition or undiagnosed symptoms or issues that I should be aware of? \_\_\_\_\_  
if yes please explain \_\_\_\_\_

I understand that the bodywork that I receive is provided for the purpose of relaxation and the relief of muscle tension. If I experience any pain or discomfort during or after the session, I will immediately inform the practitioner so that the pressure or strokes can be adjusted to my level of comfort. I also understand that bodywork is not a substitute for medical treatment and that no diagnosis will be given and that nothing said during the session should be construed as medical advise. I affirm that I have stated all my known medical conditions and answered the questions honestly. I also agree to update the practitioner of any change in my medical profile and understand that there shall be no liability on the part of the practitioner if I fail to do so. I understand that any illicit or sexually suggestive remarks made by me will result in the termination of the session and that I will be expected to pay for the scheduled appointment.

Signature \_\_\_\_\_ Date \_\_\_\_\_