Confidential Client Information

First Name ______________________________ M.I. _________ Last Name ____

Address _______________________________ City ________________ State _____ Zip _________ Birth Date _________

Home Phone ________________ Work Phone ________________ E-mail ____

Would you like to receive information regarding upcoming events or classes in Integrative Medicine via e-mail? Yes No

Employer ____________________ Occupation _____________________ Primary Care Physician _____________________

Emergency Contact ______________________ Phone ______________ Relationship _______________________________

Have you ever received a therapeutic massage? _____ Yes _____ No If yes, when? _______________________________

Allergies ____

Current Medications ____

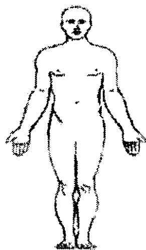
List any surgeries or accidents ____

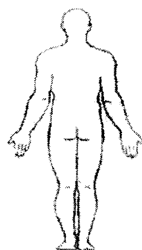
List stress reduction activities or exercise, include frequency ____

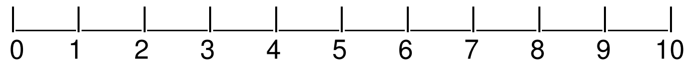
Reason for today's visit ___________________________________ Areas of discomfort _______________________________

____

Please circle any areas of pain or discomfort in the diagram below:







Please mark level of discomfort
0 being no pain and 10 being the highest level of pain

I understand that massage therapists do not diagnose illness, disease, or any physical or behavioral disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform joint mobilization. I acknowledge that massage therapy is not a substitute for medical examination or diagnosis, and it is recommended that a physician be seen for that service.

It is my choice to receive therapeutic massage as a form of therapy. I understand that treatment given is designed to address the care and prevention of myofascial pain and dysfunction.

I have stated all medical conditions that I am aware of, and will update the massage therapist of any changes in my health status.

Permission to consult with Physician? _____ Yes _____ No

____ ______________________________

Signature Date

#9029