Client Contact Information

First name *

Enter your first name

Last name *

Enter your last name

Phone Number *

(___) ___-____

Email *

example@example.com

Birth date *

Select month

Select day

Select year

Street address

Enter street address

City

Enter city

Contact Name

State

Enter state

Zip code

Enter zip code

Emergency Contact Information

Name

Bobby jo

Phone Number

555-555-5555

How did you hear about us?

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Please check the box if you have any of the following:

- [ ] Asthma
- [ ] Shortness of Breath
- [ ] Bronchitis
- [ ] Chronic Cough
- [ ] Emphysema
- [ ] Blood Clots
- [ ] Cold Hands
- [ ] High Blood Pressure
- [ ] Pacemaker
- [ ] Varicose Veins or Spider Veins
- [ ] Cardiovascular Accident
- [ ] Low Blood Pressure
- [ ] Congestive Heart Failure
- [ ] Phlebitis
- [ ] Cerebral-vascular Accident
- [ ] Heart Attack
- [ ] Stroke
- [ ] Lymphedema
- [ ] Cold Feet
- [ ] Heart Disease
- [ ] Thrombosis/Embolism
- [ ] Myocardial Infarction
- [ ] Bruise Easily
- [ ] Skin Irritations
- [ ] Hypersensitive Reaction
- [ ] Skin Conditions
- [ ] Melanoma
- [ ] Ear Problems
- [ ] Hearing Loss
- [ ] Sinus Problems
- [ ] Vision Problems
- [ ] Vision Loss

- [ ] Migraines
- [ ] Headaches
- [ ] Jaw Pain (TMJD)
- [ ] Athlete's Foot
- [ ] Contagious Respiratory Conditions
- [ ] Hepatitis
- [ ] Herpes
- [ ] Skin Conditions
- [ ] HIV
- [ ] Pregnancy
- [ ] Reproductive Issues
- [ ] Burning
- [ ] Numbness
- [ ] Tingling
- [ ] Stabbing Pain
- [ ] Cerebral Palsy
- [ ] Parkinsons
- [ ] Multiple Sclerosis
- [ ] Herniated Disc
- [ ] Allergies
- [ ] Dizziness

Allergy list

- [ ] Cancer
- [ ] Hemophilia
- [ ] Mental Illness
- [ ] Surgical Pins or Wire

Any Surgeries? if yes, when and where. Please include cosmetic. *

- [ ] Anaphylaxis
- [ ] Crohn's Disease
- [ ] Epilepsy

- [ ] Arthritis
- [ ] Osteoarthritis
- [ ] Rheumatoid Arthritis
- [ ] Joint swelling
- [ ] Artificial Joints/Special Equipment
- [ ] Diabetes type 1
- [ ] Diabetes type 2
- [ ] Fibromyalgia
- [ ] Thyroid problems
- [ ] Hypoglycemia
- [ ] Anemia

areas of joint issue

- [ ] Loss of Sensation
- [ ] Osteoporosis
- [ ] Shingles
- [ ] Stress
- [ ] Digestive Conditions
- [ ] Insomnia
- [ ] Chronic back pain
- [ ] Gout
- [ ] Lupus
- [ ] Other Diagnosed Diseases
- [ ] Other Medical Conditions

MEDICATIONS

Please list any medications or drugs you are currently on, for example, Statins or warfarins.

Are you on any high blood pressure or high cholesterol medication or blood thinners?

Allergies or Skin sensitivities your provider should be aware of?

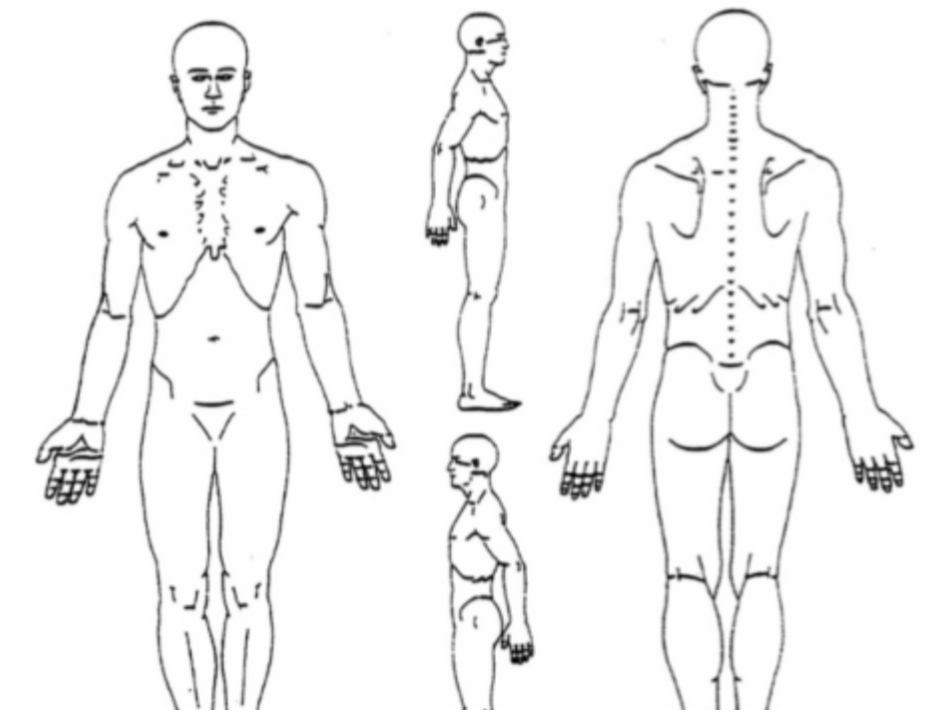
Have you ever experienced a professional massage or bodywork session? *

Do you have any specific area you would like us to focus on today? *

Do you have any specific area you would like us to avoid today? *

Are you feeling any numbness or tingling in any areas? *

Click or tap the area(s) in question and describe sensation(s) i.e. tight, sharp pain, sore, bruising, dull ache, etc.



Cause of injury or concern

Issues to Address (if any)

If you are currently experiencing pain, how would you rate your pain on a scale of 1-10? 1 being good, 10 being the worst pain ever.

example: upper back 6/10, neck 5/10

What activities make your pain worse?

What helps you relive your pain?

Treatment Goals

How long since first noticed

Past treatments ?

recent history

In the past 2 weeks...

Have you been sick, or around anyone sick in the last week? *

Are you currently feeling any numbness or tingling in any areas? *

Have you consumed alcohol within the last 24 hours? *

Have you used any Marijuana products within the last 30 days? *

Have you taken any pain medications in the past 24 hours? *

Have you had and surgeries in the past 8 weeks? If yes, where and when? *

Do you currently have any difficulty laying on your back, side or stomach? *

Have you had any new tattoos in the past 8 weeks? If yes, where and when? *

Massage can blur a new tattoo

If you need to focus work on your thighs or glutes, do we have your permission to uncover your glutes? *

yes or no

Signature for consent to uncover glutes if needed.

Sign above

Please sign if permission is granted.

If you need to focus work on your chest muscles, do we have your permission to uncover your chest if needed? *

yes or no

Signature for consent to uncover chest if needed.

Please sign above if permission is granted

I will tell my practitioner of all discomforts I have, no matter how small, & I will communicate as best I can with my therapist, so that I may have the best treatment possible. *

Sign above

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Client Waiver Form

Please take a moment to read and initial the following information:

- I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.
- If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.
- I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.
- I affirm that I have notified my therapist of all known medical conditions and injuries.
- I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.
- I understand that massage is entirely therapeutic and non-sexual in nature.
- By signing this release, I hereby waive and release my therapist, Steve Thompson and Steve Thompson Massage Therapy LLC from any and all liability, past, present, and future relating to massage therapy and bodywork.

Signature *

Sign above

I have read the statement above and agree to all the policies *

MM-DD-YYYY