

Confidential Client Information

Opt-in to receive text messages for special discounts and donation drives to legitimate charities. (no more than 2 texts in a month maximum)

Name _____ Phone () _____ Birthday _____

Address _____ City _____ State _____ Zip _____

E-mail: _____ Male Female

Referred by: _____ Phone () _____

In case of emergency: _____ Phone () _____

Occupation: _____ Physician: _____

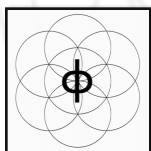
Health Insurance Carrier: _____

Check if you do **NOT** want to receive our Weekly Epiphanies E-Newsletter. Our Weekly Epiphanies include special discounts just for those on the newsletter, a weekly somatic exercise/stretch, recipe, scientific abstracts, wellness awareness, compelling videos/speeches, inspirational quotes, humor, photography, art, movie, music & book suggestions all within a PDF format!
We do not sell, trade or otherwise divulge ANY of your information. We keep all data completely confidential!

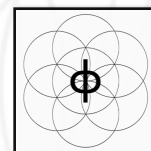
Have you ever experienced a professional massage or bodywork session?: Yes No How recently?

What are your goals? (stress relief, pain relief, relaxation, improve range of motion, etc.) _____

What kind of pressure do you prefer? light medium firm



Pain Relief is Just the Beginning™



Informed Consent

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation & 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 & 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 & 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. My signature acknowledges that I have received a copy of the HIPPA Privacy notice.

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____

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.

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

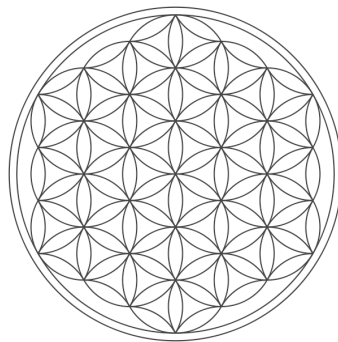
- | | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you frequently suffer from stress? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you bruise easily? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No Any broken bones in the past two years? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you experience frequent headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No Any injuries in the past two years? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have tension or soreness in a specific area?
Please specify _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from arthritis? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing contact lenses? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have cardiac or circulatory problems? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing dentures? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from back pain? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have high blood pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have numbness or stabbing pains? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you taking high blood pressure medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No Are you sensitive to touch or pressure in any area? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from epilepsy or seizures? | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had surgery? Explain below. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from joint swelling? | <input type="checkbox"/> Yes <input type="checkbox"/> No Other medical condition, or are you taking any
medications I should know about? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have varicose veins? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any contagious diseases? | Comments _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have osteoporosis? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any allergies? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had a case of shingles? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Been diagnosed with a bleeding condition such as hemophilia? | |



Pain scale 1 being low 10 being high.

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1, 2, 3, 4, 5, 6, 7, 8, 9, 10

Circle the areas that you want addressed as well as the areas that give you chronic pain/stiffness, aches, etc.



Notate if any area gives you numbness, tingling or burning sensations.

Any history of joint dislocation needs to be written down to ensure proper techniques are provided.

