

# Confidential Client Information

Please print legibly

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Main phone (cell/home/work): \_\_\_\_\_ Alternate phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Referred by: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Please circle any of the following which are current, recent (within 1-2 years) or ongoing :**

pregnant or trying to get pregnant      cancer      back pain      joint injuries, pain or swelling

cardiac or circulatory      stress      bruise easily      osteoporosis

high or low blood pressure      arthritis      seizures      varicose veins

headache: rare-occasional-frequent      allergies/asthma      diabetes      contagious disease

limited range of motion, numbness or sharp pain, sensitive to touch or pressure in any area

Do you wear contact lenses? NO YES      ...dentures? NO YES      ...prosthetics? NO YES

Do you have any implants (joints, plates, screws, pacemaker or other electronic devices, etc.)? NO YES

Details: \_\_\_\_\_

What conditions are you taking medications for?: heart blood thinners blood pressure thyroid pain diabetes

Other?: \_\_\_\_\_

List accidents, injuries, broken bones surgeries, or other medical/health conditions not covered above.

\_\_\_\_\_  
\_\_\_\_\_

- I agree to update my information as needed.
- I understand that the bodywork I receive is provided for the purpose of relaxation, stress relief, and relief of neuromuscular tension, aches, and pains. If I experience any pain or discomfort during the session(s), I will inform the practitioner so that pressure/strokes/technique may be adjusted to my comfort level.
- I further understand that bodywork is not a substitute for medical examination, diagnosis or treatment and that I should see an appropriate physician or other health care provider for any medical or psychological condition.
- I give permission for the application of appropriate techniques and modalities which may include western manual therapy, Asian bodywork therapy, auriculotherapy, cupping, Microcurrent Point Stimulation (MPS), craniosacral, cranial/structural, TMJ and intraoral therapy, light, sound, heat, essential oils and muscle testing, for as long as I remain a client.
- I may decline any modality or any technique at any time.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Confidential Client Information

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## Parent or Guardian consent for treatment of minor/dependent.

I hereby authorize massage/bodywork for my child/dependent.

I agree to be present during all sessions.

Date: \_\_\_\_\_

Parent/Guardian, Print Name: \_\_\_\_\_  
(Circle one)

Sign: \_\_\_\_\_

**Missed Appointment: Half Fee**

**Late cancellation (less than 24 hours): Half Fee**