Body Kneads Client History Form

Please print clearly, you may use back of page for further details. This information is critical to your treatment as it may affect the manner in which your treatment is structures. All information disclosed will be kept strictly confidential.

Name: _____ Date of Birth: _____

Home Phone : _____ Work: _____ Cell:_____

Email: _____ Occupation: _____

Home Address: _____

City, State, Zip: _____

Emergency Contact: _____ Phone: _____

How did you hear about my practice? _____Have you had therapeutic massage before? YES / NO / MANY

What are your expectations or goals for treatment?_____

What is the amount of stress/tension in your life? 1 2 3 4 5 6 7 8 9 10

None Average Extreme

Please circle any painful or tense areas where you tend to hold your stress.

Head/Face Neck/Shoulders Arms/Hands Abdomen Low Back Mid Back Legs/Feet

What physical activities do you do on a daily or weekly basis? _____

_____

Are you currently under a physician's care? YES / NO If yes, for what condition? _____

List all current medications/vitamins you take: _____

_____How much water do you drink daily?_____

For your safety I must be aware of all medical conditions, please circle any current or past conditions.

Allergies _____ Angina Arthritis Asthma Blood Clots Cancer Communicable Diseases Diabetes Disc Problems Edema Fibromyalgia Heart Disease Hepatitis Hypertension Immune System Conditions Infections IBS Migraines/Headaches Numbness/Altered Sensation Pregnancy Sciatica Stroke Surgeries Varicose Veins Whiplash

Other/Surgery Details_____

I verify that all information provided is correct and current to the best of my knowledge. I understand that any information provided by the therapist is for educational purposes only and is not prescriptive or diagnostic in nature. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no lifetime liability on the therapist's part should I forget to do so. A referral from your primary care provider may be required prior to service being provided.

I understand that massage or bodywork I receive is provided for the basic purpose of relaxation and relief of muscle tension. If I experience any pain or discomfort during the session I will notify the therapist immediately. It also understood that any elicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and full payment is expected.

Cancellation Policy: 24 hours advance notice of cancellation is required or a $30 cancellation fee will be charged. _____

Initials

_____

Signature

Today's Date