MYOKINETIC
MASSAGE THERAPY

MYOKINETIC MASSAGE THERAPY, PLLC
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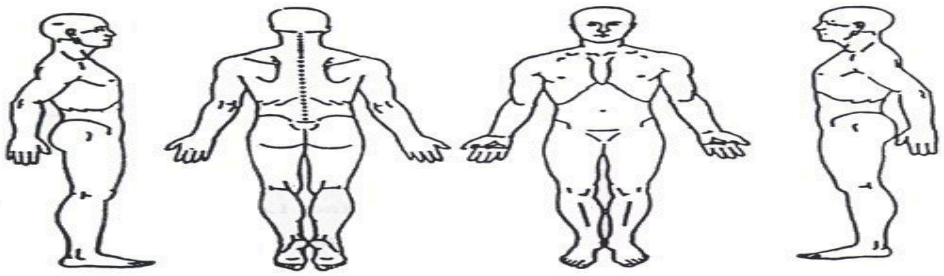
Full name: _____ **Primary Phone**: _____
Mailing Address: _____ **City, State & Zip**: _____
Email Address: _____ **Occupation / Profession**: _____
Date of Birth: _____ **Referred By**: _____
Emergency Contact Person: _____ **Contact Phone**: _____

The following information will be used to help plan a safe and effective treatment plan.

- Have you ever had a **professional massage**? ○Yes ○No – Frequency: _____
- What are your main **goals** for this session? _____
- Please specify any **target body areas** experiencing pain, tension, or discomfort: _____
- When did your symptoms **first begin**? Years? Months? Weeks? Days? _____
- Is the condition currently **getting better or worse**? ◯ Improving ◯ Worsening
- Is your pain **constant** or **intermittent**? _____
- On a scale of 1 to 10 (10 being severe/unbearable), rate your **pain intensity**: _____
- **Pain qualities/characteristics**: ◯ Sharp ◯ Dull ◯ Burning ◯ Numbness ◯ Stiffness ◯ Swelling
- Does this pain affect or disrupt your: ◯ Work ◯ Sleep ◯ Daily Activities ◯ Exercise
- Which **movements or activities** trigger **difficulty or pain**:
  ◯ Sitting ◯ Standing ◯ Walking ◯ Side Bending ◯ Rotation ◯ Flexion ◯ Extension
- Do you experience **pain or discomfort while resting or lying down** in any of these positions?
  ◯ Back ◯ Side ◯ Stomach ◯ No issues
- What is your customary **sleeping position**: ◯ Back ◯ Left Side ◯ Right Side ◯ Stomach
- **Dominant hand**: ◯ Right ◯ Left ◯ Ambidextrous
- Do you **sit for extended periods** while driving or working at a desk? ○ Yes ○ No
- Do your daily hobbies, sports, or work require **repetitive motions**? ○ Yes ○ No
- What previous treatments have you received for this issue? ◯ Medications ◯ Surgery ◯ Physical Therapy
  ◯ Chiropractic ◯ Acupuncture ◯ Massage ◯ None ◯ Other _____
- Which modalities interest you: ◯ Deep Tissue Massage ◯ Orthopedic Massage ◯ Myofascial Release
  ◯ Structural Integration ◯ Cupping ◯ Gua Sha ◯ Visceral Manipulation
- Do you have **allergies or sensitivities** to any oils, lotions, ointments, nuts, or fruits? _____
- Please list any essential oils you prefer or would like avoided during your session:
  ◯ Eucalyptus ◯ Lavender ◯ Peppermint ◯ Citrus ◯ Patchouli ◯ Other: _____

Mark any specific areas that you experience pain:



RIGHT L - *BACK* - R R - *FRONT* - L *LEFT*

Please mark to indicate if you have or had any of the following:

◯ AIDS/HIV	◯ COVID-19	◯ High Cholesterol	◯ Osteoporosis
◯ Arthritis	◯ Crohn's Disease	◯ Insomnia	◯ Pacemaker
◯ Atherosclerosis	◯ Decreased Sensation	◯ Joint Replacement	◯ Varicose Veins
◯ Blood Clots	◯ Diabetes	◯ Kidney Disease	◯ Pinched Nerve
◯ Bronchitis / Asthma	◯ Diastasis	◯ Knee Pain / Injury	◯ Plantar Fasciitis
◯ Cancer / Tumors	◯ Digestion Issues	◯ Liver Disease	◯ Pregnancy
◯ Carpal Tunnel	◯ Easy Bruising	◯ Low Blood Pressure	◯ Psychiatric Care
◯ Chronic Headaches	◯ Elbow Pain / Injury	◯ Lupus	◯ Recent Surgeries
◯ Cosmetic Surgery	◯ Epilepsy	◯ Lymphedema	◯ Rheumatoid Arthritis
◯ Fibromyalgia	◯ Fractures	◯ Migraines	◯ Sciatica
◯ Frozen Shoulder	◯ Heart Conditions	◯ Multiple Sclerosis	◯ Scoliosis
◯ Hepatitis	◯ Hernia	◯ Neck Pain / Injury	◯ Skin Disorders
◯ Herniated Disc	◯ High Blood Pressure	◯ Nerve Pain	◯ Strains / Sprains
◯ Stroke	◯ TMJ	◯ Trauma / PTSD	◯ Open Sores

◯ Physical or Sexual Abuse (Please discuss privately with practitioner if applicable to ensure safe, tailored care)

◯ Other conditions / details: _____

1. Purpose of Session: I understand that the massage session is designed to ease muscular tension, promote relaxation, and support overall well-being. Should I experience any pain or discomfort at any point during the session, I will inform the practitioner immediately so they can adjust the positioning, pressure, or techniques accordingly.

2. Clothing and Professional Draping: I understand that I may undress or stay clothed to my level of personal comfort. Professional draping techniques will be used at all times to ensure my privacy, safety, and personal boundaries are fully respected.

3. Scope of Practice: I recognize that massage therapy does not replace examination, medical diagnosis, or treatment by a physician. I should consult a qualified healthcare professional for any physical or mental health conditions. Massage therapists do not diagnose medical conditions, prescribe treatments, or perform medical procedures, and no statement made during the session should be construed as medical advice.

4. **Health Disclosure and Liability:** Because specific medical conditions may affect the safety of massage treatment, I confirm that I have disclosed all known medical conditions and health history accurately. I agree to promptly notify my therapist of any updates to my health status, and I acknowledge that the practitioner is not responsible for complications resulting from undisclosed health information.

Would you like to be notified of promotions or updates for Myokinetic Massage Therapy, PLLC via:

◯ Email ◯ Text Messages ◯ Phone Calls ◯ Postal Mail ◯ Not Interested

Signature of Client _____ Date: _____

Licensed Massage Therapist _____ Date: _____

Therapist Notes:

*S:*_____

*O:*_____

*A:*_____

*P:*_____

Revised 8.26.26