

CLIENT INFORMATION - CONFIDENTIAL

Name _____ Phone _____ Cell _____
 Address _____ City, State, Zip _____
 Email _____ Occupation _____
 Date of Birth _____ Referred By _____
 Emergency Contact Name _____ Phone _____

*The following information will be used to help plan a safe and effective treatment plan.
 Please answer all questions to the best of your knowledge.*

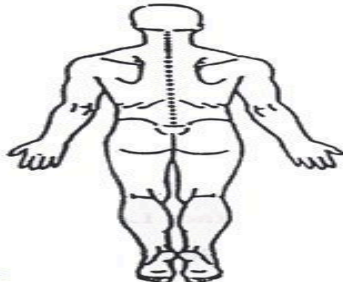
- Have you had a **professional massage** before? Yes; No; How often? _____
- What are your **goals** for this therapy session? _____

- Is there a **specific area** of the body where you are experiencing tension, stiffness, pain or discomfort?
 If yes, please explain _____
- When did your symptoms **first appear**.... Years? Months? Weeks? Days? _____
- Is this condition getting **progressively worse**? Yes No Unknown
- Rate the **severity of your pain** on a scale of 1 to 10 (being unbearable) _____
- **Type of pain:** Sharp Dull; Burning; Cramps; Numb; Stiff; Swelling
- Is the sensation **constant** or does it **come and go**? _____
- Does it interfere with: Work; Sleep; Daily Routine; Exercise; Other _____
- Are you Right handed; Left handed; Ambidextrous _____
- Favorite **sleep positions** are your back, side, stomach or a mix? _____
- Do you have **pain or discomfort sleeping or lying** on your: Back; Side; Stomach; No difficulties
- Activities or **movements** that are **painful or difficult** to perform:
 Sitting; Standing; Walking; Side Bending; Rotation; Flexion; Extension
- Are you **wearing**: contact lenses dentures hearing aid prosthetics?
- Do you **sit for long hours** at a workstation or driving? Yes No
- Do you perform any **repetitive movement** in your work, sports or hobbies? Yes No
 If yes, please describe: _____
- How do you feel that **stress** from your work, family or other aspect of your life has affected your health?
 In the form of: muscle tension anxiety insomnia irritability other _____
- Does it **interfere** with: Work; Sleep; Daily Routine; Exercise; Other _____

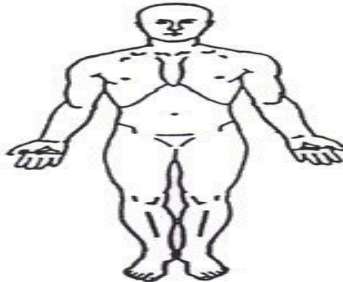
Mark any specific areas that you experience pain:



RIGHT



L - BACK - R



R - FRONT - L



LEFT

- What treatments have you already received for your condition? Medications Surgery
 Physical Therapy Chiropractic Acupuncture None Other _____
- What type of treatments are you interested in: Orthopedic Massage Deep Tissue Massage Myofascial Release
 Hot Stones Cupping Gua Sha Structural Integration Visceral Manipulation
 I'm not sure ***Please note that Cupping and Gua Sha will temporarily leave marking or bruising**
- Do you have **allergies or sensitivity** to oils, lotions, ointments, fruits or nuts? Yes or No _____
- Do you **dislike** the scent of: Eucalyptus; Lavender; Citrus; Peppermint; Patchouli; Ginger

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

- | | | | |
|---|---|--|--|
| <input type="radio"/> AIDS/HIV | <input type="radio"/> Knee Pain / Injury | <input type="radio"/> Arthritis | <input type="radio"/> Diastasis |
| <input type="radio"/> Trauma | <input type="radio"/> Elbow Pain / Injury | <input type="radio"/> Bronchitis/Asthma | <input type="radio"/> Pregnancy |
| <input type="radio"/> Frozen Shoulder | <input type="radio"/> Stroke | <input type="radio"/> High Cholesterol | <input type="radio"/> Carpal Tunnel |
| <input type="radio"/> TMJ | <input type="radio"/> Fractures | <input type="radio"/> Kidney Disease | <input type="radio"/> Lupus |
| <input type="radio"/> Blood Clots | <input type="radio"/> Recent Surgeries | <input type="radio"/> Diabetes | <input type="radio"/> Insomnia |
| <input type="radio"/> Liver Disease | <input type="radio"/> Cosmetic Surgery | <input type="radio"/> Chrons | <input type="radio"/> Multiple Sclerosis |
| <input type="radio"/> Osteoporosis | <input type="radio"/> Joint Replacement | <input type="radio"/> Varicose Veins | <input type="radio"/> Hepatitis |
| <input type="radio"/> Epilepsy | <input type="radio"/> Low Blood Pressure | <input type="radio"/> Pinched Nerve | <input type="radio"/> Digestion Issues |
| <input type="radio"/> Chronic Headaches | <input type="radio"/> High Blood Pressure | <input type="radio"/> Herniated Disc | <input type="radio"/> Skin Disorders |
| <input type="radio"/> Migraines | <input type="radio"/> Heart Condition | <input type="radio"/> Psychiatric Care | <input type="radio"/> Fibromyalgia |
| <input type="radio"/> COVID-19 | <input type="radio"/> Pacemaker | <input type="radio"/> Rheumatoid Arthritis | <input type="radio"/> Hernias |
| <input type="radio"/> Neck Issues | <input type="radio"/> Easy Bruising | <input type="radio"/> Tumors | <input type="radio"/> Strains/Sprains |
| <input type="radio"/> Decreased Sensation | <input type="radio"/> Atherosclerosis | <input type="radio"/> Cancer | <input type="radio"/> Open Sores |
| <input type="radio"/> Other _____ | | | |

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that I can stay as dressed or undressed as I feel comfortable during therapy. I further understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician or other qualified medical specialist for mental or physical ailments that I am aware of. I understand that massage therapists are not qualified to perform adjustments, diagnose, prescribe or treat any physical or mental illness and that nothing said in the course of the session should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all the questions honestly. I agree to keep the therapist updated to any changes in my medical profile and understand that there shall be no liability on the therapist's part if I should fail to do so.

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 _____

Signature of Licensed Massage Therapist _____ Date _____

Therapist Notes:

S: _____
 O: _____
 A: _____
 P: _____