MYOKINETIC
MASSAGE THERAPY

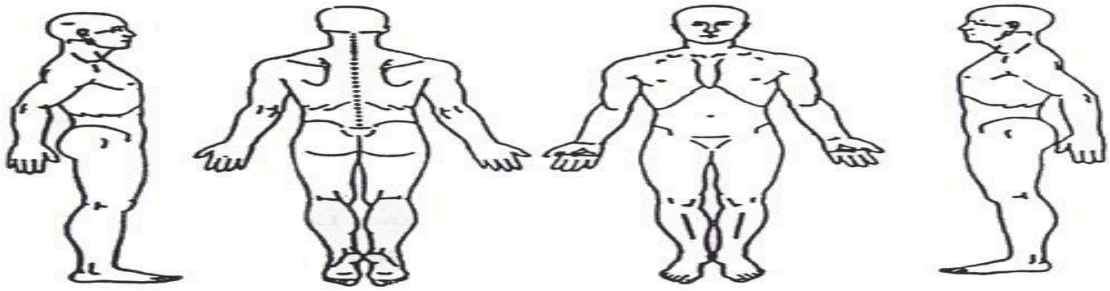
CLIENT INFORMATION - CONFIDENTIAL

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.

- Have you had a **professional massage** before? ○ Yes ○ No Frequency? _____
- What are your **goals** for this therapy session?_____
- Which **specific areas** are experiencing tension, stiffness, pain or discomfort _____
- When did your symptoms **first appea**r…. Years? Months? Weeks? Days? _____
- Is this condition getting **progressively better or worse**? ◯ Better ◯ Worse
- Rate the **severity of your pain** on a scale of 1 to 10 (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
- What are your usual **sleep positions**: ◯ Back ◯ Right Side ◯ Left Side ◯ Stomach
- 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
- 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
- Does it **interfere** with: ◯ Work ◯ Sleep ◯ Daily Routine ◯ Exercise ◯ Other _____
- What treatments have you already received for your condition? ◯ Medications ◯ Surgery ◯ Physical Therapy
  ◯ Chiropractic ◯ Acupuncture ◯Massage ◯ None ◯ Other _____
- What type of treatments are you interested in: ◯ Orthopedic Massage ◯ Deep Tissue Massage ◯ Cupping
  ◯ Gua Sha ◯ Structural Integration ◯ Myofascial Release ◯ Visceral Manipulation
- Do you have **allergies or sensitivity** to oils, lotions, ointments, fruits or nuts? _____
- Mark any essential oils you enjoy and want to use, or cross out any to avoid during your session
  ◯ Eucalyptus ◯ Lavender ◯ Peppermint ◯ Citrus ◯ Patchouli ◯ _____

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

◯ Physical or Sexual Abuse (Please tell therapist in private if relevant for additional safe and respectful care)

◯ Other _____

I understand that the massage I receive is intended to support relaxation, reduce muscular tension, and promote overall well-being. If I experience any pain or discomfort during the session, I will immediately inform the therapist so adjustments can be made to pressure, technique, or positioning.

I understand that I may remain as dressed or undressed as I feel comfortable, and that all sessions will be conducted with professional draping and respect for my boundaries at all times.

I acknowledge that massage therapy is not a substitute for medical diagnosis, treatment, or examination, and that I should consult with a licensed healthcare provider for any physical or mental health concerns. I understand that massage therapists do not diagnose, prescribe, or treat medical conditions, and nothing said during my session should be interpreted as such.

Because certain health conditions may affect the safety or appropriateness of massage, I confirm that I have accurately disclosed all known medical information. I agree to update my therapist with any changes in my health status, and understand that the therapist is not liable for any complications that may arise from my failure 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: _____

Licensed Massage Therapist _____ Date: _____

Therapist Notes:

*S:*_____

*O:*_____

*A:*_____

*P:*_____

Revised 7.23.25