**Client Information:**

**Date: \_\_\_\_\_\_\_\_\_\_Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB:\_\_\_\_\_\_\_\_\_\_\_\_Sex: M / F**

**Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact (name/phone #):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

What are your goals for treatment?

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

Are you experiencing tension, stiffness, discomfort or pain from a recent injury/surgery? Y/N

Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_

Are you taking blood thinners? Y/N

Do you have any allergies?  Y/N

**\*Circle/describe any of the following health conditions that currently apply to you:**

**Musculoskeletal**

Bone or joint disease

Tendonitis/Bursitis

Arthritis/Gout

Jaw Pain (TMJ)

Migraines/Headaches

Osteoporosis

**What the CLIENT can expect:**

-A welcoming and comfortable environment where clients feel the freedom to express themselves and their feelings without judgment from their therapist.

-Therapist does not claim to diagnose, treat or prescribe, but may recommend personal exercises/activities that may aide in the client's well being and healing process.

-Therapist claims to correctly drape clients so they feel safe and unexposed throughout the entire duration of the bodywork session.

-All client information will be kept confidential in accordance with HIPAA standards.

-Any form of sexual advances/harassment will be terms for dismissal of client from therapists care.

**What the THERAPIST expects:**

**-**Client will refrain from discussing political, racist or sexist topics while in session.

-Client information MUST be up-to-date, before receiving massage, including but not limited to: Name, Phone #, Address, Emergency Contact info., Liability Waiver form and ANY medical related concerns/diagnoses that may affect the outcome of the session.

-Any form of sexual advances/harassment will be terms for dismissal of client from therapists care.

-Therapist requires payment for services upon scheduling OR before services are provided.

-Cancellations less than 24-hours prior to scheduled session time will be billed for the entire session, with payment due ASAP.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Client Printed Name

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Client Signature

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Parent/Guardian Printed Name

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Parent/Guardian Signature

**Circulatory**

Heart Condition

Phlebitis/Varicose Veins

Blood Clots

High/Low Blood Pressure

Lymphedema

Thrombosis/Embolism

**Respiratory**

Breathing Difficulty/Asthma

Emphysema

Allergies, specify:

Sinus Problems

**Nervous System**

Shingles

Numbness/Tingling

Pinched Nerve

Chronic Pain

Paralysis

Multiple Sclerosis

Parkinson’s Disease

**Reproductive**

Pregnant, stage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ovarian/Menstrual Problems

Prostate

**Skin**

Rashes

Cosmetic Surgery

Athlete’s Foot

Herpes/Cold Sores

**Digestive**

Colitis/Ulcers

**Psychological**

Anxiety/Stress Syndrome

Depression

**Other**

Cancer/Tumors