In Touch

Therapeutic Massage & Bodywork

Name _____ Phone ( ) _____ DOB _____

Address _____ City _____ State _____ Zip _____

E-mail: _____ Referred by: _____ Phone ( )_____

Occupation _____ ◯Male ◯Female Physician_____ Health Insurance Carrier _____

In case of emergency: _____ Phone ( )_____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? ◯ Yes ◯ No How recently?_____

What are your massage or bodywork goals?_____

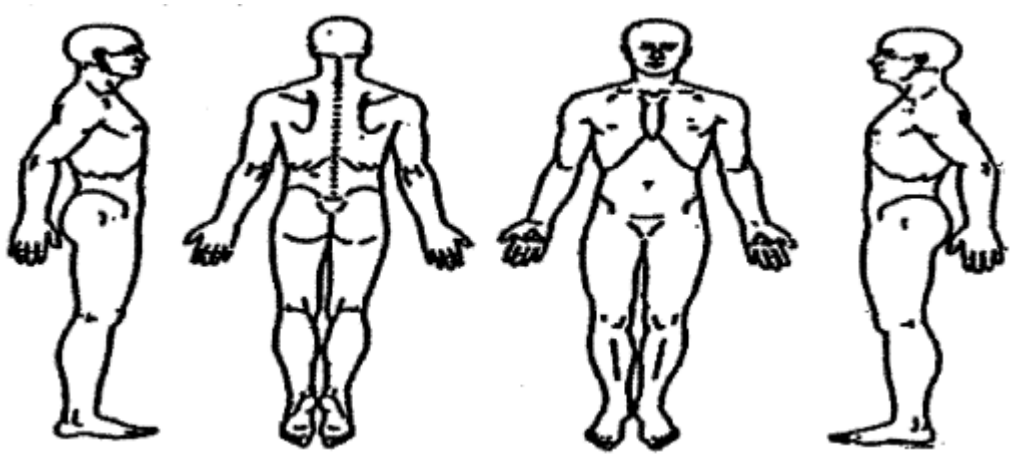
What kind of pressure do you prefer? ◯ light ◯ medium ◯ firm

If you answer "yes" to any of the following questions, please explain as clearly as possible.

◯Yes ◯No Do you frequently suffer from stress?
◯Yes ◯No Do you have diabetes?
◯Yes ◯No Do you experience frequent headaches?
◯Yes ◯No Are you pregnant?
◯Yes ◯No Do you suffer from arthritis?
◯Yes ◯No Do you suffer from joint swelling?
◯Yes ◯No Are you wearing contact lenses?
◯Yes ◯No Are you wearing dentures?
◯Yes ◯No Do you have high blood pressure?
◯Yes ◯No Are you taking high blood pressure medication?
◯Yes ◯No Do you suffer epilepsy or seizures?
◯Yes ◯No Do you suffer from joint swelling?
◯Yes ◯No Do you have varicose veins?
◯Yes ◯No Do you have any contagious disease?
◯Yes ◯No Do you have any allergies?

◯Yes ◯No Do you bruise easily?
◯Yes ◯No Any broken bones in the past two years?
◯Yes ◯No Any injuries in the past two years?
◯Yes ◯No Do you have tension or soreness in a specific area?
Please specify _____
_____
◯Yes ◯No Do you have cardiac or circulatory problems?
◯Yes ◯No Do you suffer from back pain?
◯Yes ◯No Do you have numbness or stabbing pains?
◯Yes ◯No Are you sensitive to touch or pressure in any area?
◯Yes ◯ No Have you ever had surgery? Explain below.
◯Yes ◯No Other medical condition, or are you taking any medications I should know about?
Comments_____
_____

Please indicate areas of pain or discomfort on the diagram



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How frequent do you have symptoms?

◯ Constantly (75 – 100% of the time) ◯ Occasionally (25 – 50% of the time)
◯ Frequently (50 – 75% of the time) ◯ Not very often (1 – 25% of the time)

How would you describe the sensation?

◯ Sharp ◯ Numb
◯ Dull ◯ Tingly
◯ Scattered ◯ Short agitation with movement
◯ Uncomfortable ◯ Stronger with movement
◯ Burning ◯ Shooting
◯ Strong ◯ Electric
◯ Rigid ◯ Other: _____

How have the symptoms changed over time?

◯ Worse ◯ Same ◯ Better

Have you seen someone about this problem?

◯ Chiropractor ◯ Neurologist ◯ Physician
◯ Emergency Room ◯ Orthopedist ◯ Other:_____
◯ Massage Therapist ◯ Physical Therapist ◯ I haven't seen anyone about this

How do you think this problem began? _____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/ bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature _____ Date _____

Practitioner Signature _____ Date _____

Consent Treatment of Minor: By my signature below, I hereby authorize Amber Solis, LMT to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____