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**Hands On OC Massage & Bodywork**

**with Michael Roberson, CMT, BCTMB**

1601 Dove Street, Suite 278, Newport Beach, CA 92660

949.292.9207 HandsOnOCMassage@gmail.com

www.HandsOnOC.com

**New Patient/Client Information Sheet**

Please print legibly and answer all of the questions.

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (preferred \_\_\_)

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (preferred \_\_\_ text \_\_\_)

Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (preferred \_\_\_)

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hobbies/Activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In Case of Emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How were you referred? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Client’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a massage before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If so, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results? Like? Dislike? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your major complaints/issues? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Do you know what brought this on? If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

When did this first happen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has this happened before? \_\_\_\_\_\_\_\_ Does it feel as if it is getting worse? ­­\_\_\_\_\_\_

Have you seen a doctor about this? \_\_\_\_\_\_\_\_

Does this interfere with work? \_\_\_\_\_\_\_ sleep? \_\_\_\_\_\_\_ daily routine? \_\_\_\_\_\_\_\_

What, if anything, have you tried to find relief? And results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please indicate where you are experiencing pain, surgeries, implants A close up of a necklace

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**I may need to contact and consult with your physician have his/her permission to provide a massage. Please list all your doctors’ names and phone number for each. A quick confirmation will allow the massage session to continue. If unable to obtain permission, the session could be post-phoned. Your permission to share your medical information is required.**

**Doctor’s Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Specialty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Doctor’s Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Specialty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Doctor’s Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Specialty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby give my permission to allow my physician to share my medical information with my massage therapist and my massage therapist, Michael Roberson, CMT BCTMB to share my information with you.**

Your Signature as Permission ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_

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## General Medical Information

If you answer “yes” to any of the following questions, please explain prior to your massage. Answers to specific issues can be made in the “Comment” section. Please indicate what numbered question you are answering to on the following page.

1. Y / N Are you at least 18 years of age? If not, please have parent/guardian fill out Minor Intake form.
2. **Y / N Are you pregnant? Think you might be pregnant? Or trying to get pregnant? (If pregnant, fill out Pregnancy Intake form)**
3. Y / N Are you wearing contact lenses?
4. **Y / N Do you have high or low blood pressure? If yes, be specific of the condition and list all medications you are taking for this?**
5. Y / N Are you diabetic? If yes, what type and medications?
6. **Y / N Do you have any communicable diseases? (Herpes, HIV, STD’s, hepatitis, etc.) If yes, be specific of the condition(s) and any medications you are taking.**
7. Y / N Are you allergic to anything (i.e.: seed nuts)? If yes, be specific of the allergens and list any medications you are taking.
8. **Y / N Do you have any conditions that require the use of an epi-pen? If yes, be specific of the condition and the medication. Also, do you have the epi-pen with you at all times?**
9. Y / N Do you suffer from seizure disorders or epilepsy?

If yes, be specific of the condition(s) and any medications you are taking.

1. **Y / N Do you experience frequent headaches? If yes, what area(s) of your head do you experience these and any medications you are taking.**
2. Y / N Do you have soreness or tension in a specific area?
3. **Y / N Do you have cardiac or circulatory problems? If yes, be specific of the condition and any medications you are taking.**
4. Y / N Do you have numbness or stabbing pains anywhere? If yes, be specific of the areas you are experiencing these.
5. **Y / N Do you suffer from back pain? If yes, be specific at to where.**
6. Y / N Do you have any other medical condition(s) that I should be aware of and other medications and supplements you are taking?
7. **Y / N Have had whiplash? If yes, date and direction of whiplash.**
8. Y / N Have you broken any bones? If yes, list of what was broken and when.
9. **Y / N Have you ever had surgery? If yes, please explain with procedures and dates.**
10. Y / N Been in an accident? (auto or trauma) If yes, please list date(s) and details of each occurrence.
11. **Y / N Do you have any kidney issues? If yes, please explain.**
12. Y / N Do you have any medical implant devices? If yes, please explain with dates.

Specialty forms for Minors, Pregnancy, Oncology, Burn Survivors and Special Needs are available if needed or required. Please use the following page to explain all “yes” answers. Thank you.

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If you answer “yes” to any of the pervious questions, please explain prior to your massage. Answers to specific issues can be made in the “Comment” section. Please indicate what numbered question you are answering to on this page.

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PLEASE TAKE A MOMENT TO CAREFULLY READ THE FORLLOWING INFORAMTION AND SIGN THE ACKNOWLEGDMENT.

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 the service being provided. I understand that 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 therapist so that pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should consult a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/bodywork therapist are not qualified to perform spinal or skeletal adjustment, 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. Information exchanged during the session is only educational in nature is intended to help me become more familiar and conscious of my own health status. All information exchanged is to be used at my own discretion, either to accept or to decline. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and have answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be not liability on the therapist’s part should I neglect to do so.

**Client’s**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of**

**First Session: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

California Massage Therapy Council (CAMTC 4487) **National Certification Board for Therapeutic Massage and Bodywork (NCBTMB 397447)** American Massage Therapy Association (AMTA 158318), Association of Bodyworkers and Massage Professionals (ABMP 861487)

Newport Beach Business License BT30062610, National Provider Identification (NPI 1689384562)

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**Cancellation Policy**

I respectfully request you to provide a minimum of **6-hours notice** of any schedule changes or cancellation requests. Please understand, when you cancel or miss your appointment without the said minimum **6-hour** **notice**, you will be expected to pay for the scheduled appointment.

I understand that emergencies can arise, and illness do occur at the most inopportune time. If you have a fever, cold or flu like symptoms, (or within the last 48 hours), please cancel. If you have experienced vomiting or diarrhea within the last 24 hours prior to your appointment, please cancel. Should bad weather be a concern for your own safety, please cancel.

Late cancellations due to emergency, illness, or inclement weather generally will not result in a missed session charge, but this is determined on a case-by-case basis. I provide 1 (one) “life happens” late cancellation pass that may be used in lieu of charges. This is only offered once. Additional late cancellations are expected to be paid for the service time reserved.

**Please do not risk your own (*or my own*) personal health and safety to keep an appointment.**

**Late Arrival Policy.**

It is requested that you arrive 10-15 minutes prior to your scheduled appointment to allow time to fill out any required paperwork or answer questions with your therapist. I understand that issues can arrive that may cause you to be late for your appointment. However, I ask that you call to inform me of the situation to see if we can still accommodate your appointment. If we are able to accommodate schedules, your full service will be provided. If not, the time that remains of your scheduled appointment will be provided at the full scheduled service rate. Likewise, I plan to be on time for your appointment. If I cannot do so, I will adjust your time and/or service costs accordingly.

**Inappropriate Behavior Policy**

Massage therapy is for relaxation and therapeutic purposes only. There is absolutely no sexual component to massage whatsoever. Any insinuation, joke, gesture, conversation, or request to provide illicit behavior, will result in the immediate termination of your service. You will be expected to make full payment of the scheduled service. Depending on the extent of your behavior exhibited, a report can be made with the local authorities. Treat your therapist with respect and dignity and you will be treated the same in return.

By signing below, I agree to the polices.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

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