**Personal Information**

**Basic Information**

First Name Click or tap here to enter text. Last Name Click or tap here to enter text.

Date of Birth Click or tap to enter a date. Occupation Click or tap here to enter text.

**Contact Information**

Email Click or tap here to enter text. Phone Click or tap here to enter text. [ ] Cell

Address1 Click or tap here to enter text.

Address2 Click or tap here to enter text.

City Click or tap here to enter text.

**Emergency Contact Information**

Contact Name Click or tap here to enter text. Phone Click or tap here to enter text.

Relationship Click or tap here to enter text.

Doctor’s Name Click or tap here to enter text. Phone Click or tap here to enter text.

**Complaint Information**

Primary Complaint Click or tap here to enter text.

How Long Since First Noticed Click or tap here to enter text.

Cause of Injury or Concern Click or tap here to enter text.

Past Treatment Click or tap here to enter text.

**Existing Conditions**

****

Please indicate areas of pain or discomfort

**Soft Tissue / Joint Dysfunction**

[ ] Ankles (Left)

[ ] Ankles (Right)

[ ] Feet (Left)

[ ] Feet (Right)

[ ] Hips (Left)

[ ] Hips (Right)

[ ] Legs (Left)

[ ] Legs (Right)

[ ] Knees (Left)

[ ] Knees (Right)

[ ] Shoulders (Left)

[ ] Shoulders (Right)

[ ] Arms (Left)

[ ] Arms (Right)

[ ] Hands (Left)

[ ] Hands (Right)

[ ] Neck (Left)

[ ] Neck (Right)

[ ] Upper Back (Right)

[ ] Upper Back (Left)

[ ] Mid Back (Left)

[ ] Mid Back (Right)

[ ] Lower Back (Left)

[ ] Lower Back (Right)

**Respiratory**

[ ] Asthma

[ ] Shortness of Breath

[ ] Bronchitis

[ ] Chronic cough

[ ] Emphysema

**Cardiovascular**

[ ] Blood Clots

[ ] Cold Hands

[ ] High Blood Pressure

[ ] Pacemaker

[ ] Varicose Veins

[ ] Cardiovascular Accident

[ ] Congestive Heart Failure

[ ] Low Blood Pressure

[ ] Phlebitis

[ ] Cerebral-vascular Accident

[ ] Heart Attack

[ ] Lymphedema

[ ] Stroke

[ ] Cold Feet

[ ] Heart Disease

[ ] Myocardial Infarction

[ ] Thrombosis/Embolism

**Skin**

[ ] Bruise Easily

[ ] Skin Irritations

[ ] Hypersensitive Reaction

[ ] Melanoma

[ ] Skin Conditions

**Existing Conditions Cont’d.**

**Head & Neck**

[ ] Ear Problems

[ ] Migraines

[ ] Headaches

[ ] Sinus Problems

[ ] Hearing Loss

[ ] Vision Loss

[ ] Jaw Pain (TMJD)

[ ] Vision Problems

**Infectious Conditions**

[ ] Athlete's Foot

[ ] Respiratory Conditions

[ ] Hepatitis

[ ] Skin Conditions

[ ] Herpes

[ ] HIV

**Women**

[ ] Gynaecological Conditions [ ] Pregnancy

**Family History**

[ ] Cardiovascular Conditions [ ] Respiratory Conditions

**Miscellaneous**

[ ] Allergies

[ ] Cancer

[ ] Dizziness

[ ] Haemophilia

[ ] Mental Illness

[ ] Other Medical Conditions

[ ] Surgical Pins or Wire

[ ] Anaphylaxis

[ ] Crohn's Disease

[ ] Epilepsy

[ ] Insomnia

[ ] Osteo Arthritis

[ ] Rheumatoid Arthritis

[ ] Artificial Joints / Special Equipment

[ ] Diabetes

[ ] Fibromyalgia

[ ] Loss of Sensation

[ ] Osteoporosis

[ ] Shingles

[ ] Arthritis

[ ] Digestive Conditions

[ ] Gout

[ ] Lupus

[ ] Other Diagnosed Diseases

Stress

**Neurological**

[ ] Burning

[ ] Numbness

[ ] Cerebral Palsy

[ ] Parkinsons

[ ] Herniated Disc

[ ] Stabbing

[ ] Multiple Sclerosis

[ ] Tingling

Allergies and other conditions your provider should be aware of Click or tap here to enter text.

**Medications**

Please list any medications or drugs you are currently on

Click or tap here to enter text.

**Client Waiver Form**

**Please take a moment to read and tick the following information:**

[ ]  I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.

[ ]  If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.

[ ]  I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

[ ]  I affirm that I have notified my therapist of all known medical conditions and injuries.

[ ]  I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist’s part should I forget to do so.

[ ]  I understand that massage is entirely therapeutic and non-sexual in nature.

[ ]  By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.

[ ] I have read the statement above and agree to all the policies.

Client Signature Click or tap here to enter text. Date Click or tap to enter a date.



**Rediscovering Equilibrium**

**A balanced approach to bodywork**