

Client Information

Dynamic Directions



Name _____ DOB _____
 Address _____
 City _____ State _____ Zip _____
 Home: () Cell: () Work: ()
 Email: _____
 Occupation: _____ Male Female
 Referred by: _____
 Emergency contact: _____ Phone: _____

- Have you had professional massage or bodywork before? yes No How recently? _____
- What are your massage/bodywork goals? _____

✦ If you answer "yes" to any of the following questions, please explain as clearly as possible in the space provided below ✦

- | | |
|--|---|
| 1. Do you frequently suffer from stress?..... yes <input type="checkbox"/> no <input type="checkbox"/> | 12. Do you have varicose veins?..... yes <input type="checkbox"/> no <input type="checkbox"/> |
| 2. Do you experience frequent headaches? yes <input type="checkbox"/> no <input type="checkbox"/> | 13. Do you have high blood pressure? yes <input type="checkbox"/> no <input type="checkbox"/> |
| 3. Do you suffer from joint swelling?..... yes <input type="checkbox"/> no <input type="checkbox"/> | 14. Do you have cardiac or circulatory problems? yes <input type="checkbox"/> no <input type="checkbox"/> |
| 4. Do you bruise easily?..... yes <input type="checkbox"/> no <input type="checkbox"/> | 15. Do you suffer from arthritis? yes <input type="checkbox"/> no <input type="checkbox"/> |
| 5. Do you have tension or soreness in a specific area? yes <input type="checkbox"/> no <input type="checkbox"/> | 16. Do you suffer from epilepsy or seizures? yes <input type="checkbox"/> no <input type="checkbox"/> |
| 6. Do you suffer from back pain?..... yes <input type="checkbox"/> no <input type="checkbox"/> | 17. Do you have any contagious diseases?..... yes <input type="checkbox"/> no <input type="checkbox"/> |
| 7. Do you have numbness or stabbing pains?..... yes <input type="checkbox"/> no <input type="checkbox"/> | 18. Do you have osteoporosis?..... yes <input type="checkbox"/> no <input type="checkbox"/> |
| 8. Are you sensitive to touch or pressure in any area? yes <input type="checkbox"/> no <input type="checkbox"/> | 19. Do you have any allergies? yes <input type="checkbox"/> no <input type="checkbox"/> |
| 9. Have you ever had a colon cleanse?..... yes <input type="checkbox"/> no <input type="checkbox"/> | 20. Do you have any other medical condition, or are you taking any |
| 10. Have you had any serious injuries in the past 2 years?..... yes <input type="checkbox"/> no <input type="checkbox"/> | medications I should know about? yes <input type="checkbox"/> no <input type="checkbox"/> |
| 11. Do you have diabetes? yes <input type="checkbox"/> no <input type="checkbox"/> | |

✦ Provide your explanations here:.....

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I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief from 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 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. 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 _____

Consent to Treatment of Minor: By signing this form, I hereby authorize _____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

➤ Client Signature _____ Date _____



Name: _____ Date: _____

Why are you here? _____

Do you have pain right now? yes no If yes, where: _____

Describe any surgeries, scars, accidents, falls or injuries that you've had:

When did it happen? What happened?

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have bladder or digestive issues ? yes no If yes, please describe: _____

Use this space to describe any other issues or concerns you would like me to know about: _____

Female Clients:

Do you have uterus issues? yes no

Please describe: _____

When was your last period? _____

Have you ever had an IUD? yes no

If yes, when and for how long: _____

Number of pregnancies: _____

Number of full-term pregnancies: _____

Number of fast births: _____

Number of slow births: _____

Number of episiotomies: _____

Male Clients:

Do you have prostate issues? yes no

If yes, please describe: _____
