Client Information and Release

Martha L. Heise, LMT, RMT

Today's Date:_____

Name:	Birthdate:	
Street:	Phone:	
City: ST: Zip:	Cell:	
Occupation:	Email:	
Emergency Contact (Name and Phone):		
Physician/Healthcare Provider (Name and Phone):		
Referred By:	Do you have a physician referral/ prescription?	Yes No

The following is important in our evaluation process. Please fill these forms as specifically as possible to provide a clear picture of your present functional ability and symptoms. *Please use back page for additional comments.*

How do you feel today?

Briefly describe condition(s) motivating you to seek treatment today:

When and how did your symptoms begin?

Do these symptoms interfere with your activities of daily living (e.g. sleep, exercise, work, childcare)?	Yes No

Are there other goals/expected outcomes for receiving massage/bodywork today?

List past medical history with dates for all surgeries, accidents, and other traumas:

Circle any of the following that you currently have (if unsure, please ask):

Blood clot Infections Congestive Heart Failure Contagious Diseases Pitted Edema

List the medications you currently take and the reason for medication (Medication, for the treatment of…, Dose, Effectiveness):

Do you have a pacemaker, internal defibrillator, insulin pump, or any other implanted medical device?

Are you wearing contacts?	Yes	No	Are you wearing dentures?	Yes	No
Are you wearing a hairpiece?	Yes	No	Are you pregnant?	Yes	No
Do you currently exercise and/or participate in any sports?	Yes	No	Do you experience any discomfort, shortness of breath or pain with these activities?	Yes	No

In general, how would you characterize your lifestyle?

1 (Active) 2 3 4 (Average) 5 6 7 (Inactive)

Please place a check √ in front of each item you experience at least monthly. Place an X in front of each item you experience weekly or more frequently. Please add your comments to clarify the condition:

Headaches, Migraines	Rashes	PMS
Muscle or joint stiffness	Allergies, Hay Fever	Menopause
Muscle or joint pain	Allergies to Medicine	Endometriosis
Spasms/Cramps	Vertigo	Hysterectomy
Broken/fractured bones	Nervous stomach	Fertility concerns
Strains/Sprains	Indigestion	Prostate problem
Back or neck pain	Constipation	Loss of appetite
Shoulder pain	Gas/bloating	Memory loss, confusion, easily overwhelmed
Tightness of throat	Diarrhea	Depression
Jaw pain/TMJ	Irritable Bowel	Anxiety, worrisome thoughts
Arm, hand pain	Sinus problems	Difficulty concentrating
Leg, foot pain	Grinding of teeth	Water retention
Chest, rib pain	Concussion(s)	Frequent urination
Abdominal pain	Numbness or tingling	Urinary leakage
Problems walking	Twitching of face	Painful urination
Tendonitis	Fatigue	Breast tenderness
Bursitis	Sleep disorders	Common colds
Arthritis (rheumatoid)	Ulcers	Sore throat
Arthritis (osteoarthritis)	Paralysis	Eating disorder
Osteoporosis, degenerative spine, disk	Herpes	Diabetes (I or II)
Scoliosis	Shingles	Fybromyalgia
HIV/AIDS	Cerebral Palsy	Chronic Fatigue Syndrome
Dizziness	Epilepsy, seizures	Aneurysm
Chronic Infections	Parkinson's disease	Earache or ringing in ears
Fainting	Spinal cord injury	Eyestrain or discomfort
Cold feet or hands	Chronic pain	Hepatitis/Liver Disease
Cold sweats	Other neurological condition	Gall bladder trouble
Swollen ankles	Hot flashes	Swelling
Varicose veins	Multiple sclerosis	Bruise easily
Blood clots	Cancer	Sensitive to touch/pressure
Stroke	Anemia	Kidney disease, infection
Heart condition	Pregnancy	Shortness of breath, asthma
High or low blood pressure	Hemorrhoids	Endocrine, e.g. Thyroid conditions
Substance abuse	Lymphedema	Other

Comments:

Have you ever received professional massage/bodywork before? Yes No | How recently?

Please shade areas of pain on the diagram below.

Consent for Treatment

I understand myofascial release/bodywork may be contraindicated. A referral from my primary care physician may be required. I further understand that 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 that is beyond the scope of practice of my massage therapist. 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 should be construed as such. Because myofascial release/ 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 my therapist updated as to any changes in my medical profile and understand there should be no liability on the part of the therapist should I forget to do so. It is also my understanding that any inappropriate or sexually suggestive remarks or misconduct made by me will result in immediate termination of the session, and I will be liable for the full payment of the scheduled appointment. I understand, I will be charged for appointments I cancel or miss without 24 hours notice of my scheduled appointment. I understand that if I arrive late I will receive the remainder of the time scheduled, but will be liable for payment in full. Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____