

# Client Information

Name: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Referred By: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
In case of emergency: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

## General & Medical Information

Occupation: \_\_\_\_\_ Height: \_\_\_\_\_  Male  Female

Are you basically in good health?  Yes  No

Has there been any change to your health in the past year?  Yes  No

If so please explain: \_\_\_\_\_

Physician: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Have you ever had massage?  Yes  No Frequency: \_\_\_\_\_ Type: \_\_\_\_\_

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

Do you suffer from acne?  Yes  No Have you ever had surgery?  Yes  No  
Do you have Allergies?  Yes  No Please explain (including month & year): \_\_\_\_\_  
Specify \_\_\_\_\_

Do you have arthritis?  Yes  No Are you pregnant or nursing?  Yes  No  
Do you have high blood pressure?  Yes  No Do you wear contact lenses?  Yes  No  
If yes, what medication are you taking? \_\_\_\_\_ Do you wear dentures?  Yes  No  
Do you have a pacemaker?  Yes  No

Do you suffer from epilepsy or seizures?  Yes  No Are you currently being treated by a  
physician for any other condition?  Yes  No  
Do you suffer from claustrophobia?  Yes  No Please explain: \_\_\_\_\_

Do you have varicose veins or  
distended capillaries?  Yes  No

Do you have any contagious diseases?  Yes  No

Do you have heart disease?  Yes  No

Do you have diabetes?  Yes  No

Do you have asthma?  Yes  No

Have you ever had or are you being  
treated now for cancer?  Yes  No  
Please explain: \_\_\_\_\_

Do you suffer from any blood disorder?  Yes  No

How much water do you drink a day? \_\_\_\_ glasses

Do you exercise regularly?  Yes  No

How would you describe your overall level of stress?  
 Low  Medium  High

Do you experience frequent headaches?  Yes  No

Do you suffer from joint swelling?  Yes  No

Do you have osteoporosis?  Yes  No

Do you bruise easily?  Yes  No

Have you had any broken bones in the past 2 years?  Yes  No

Have you been in an accident or suffered any injuries in the past 2 years?  Yes  No

Do you have tension or soreness in a specific area?  Yes  No

Do you suffer from back pain?  Yes  No

Do you have numbness or stabbing pains anywhere?  Yes  No

Are you very sensitive to touch or pressure in any area?  Yes  No

Are you taking any medications (including non-prescription drugs)?

- Birth Control Pills
- Diuretics
- Vitamins/Supplements
- Hormone Therapy
- Aspirin/Ibuprofen/Acetaminophen
- Vitamin A (topical or internal)
- Other

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 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. It is my understanding that I may terminate the session at any time.

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

Practitioner Signature: \_\_\_\_\_ WCMT LIC# 3468-046 Date: \_\_\_\_\_

Consent to Treatment of Minor: By my signature below, I hereby authorize Tammy Von Allmen, WCMT LIC# 3468-046 to administer massage, bodywork or somatic therapy techniques to my child or dependent, as they deem necessary.

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_