Therapist Name:_____

Client Contact Information

Client Name:_____ Date:_____
Date of Birth:_____ Gender:_____
Address:_____City_____State_____Zip_____
Phone:_____ Email Address:_____
Referred by:_____
Emergency contact:_____ Phone:_____
Primary Doctor:_____ Phone:_____

Massage/Bodywork Information

Have you received professional massage/bodywork before? Yes or No
How recently? _____
What type of massage/bodywork do you prefer? _____

Please circle different treatments you have tried or are familiar with?
Reiki Cupping EFT Life Coaching Acupuncture Chiropractic Functional Medicine Yoga
Hula Hooping CST Nutritional Counseling Myofascial Release Trigger Point Therapy Qigong
Arvigo Therapy Crystal Healing Oncology Massage Hot Stone Guided Relaxation Tai Chi
Other: _____

What kind of pressure do you prefer? Light Medium Firm
What are your goals/expected outcome for your Therapeutic Session?
_____
_____
How are you feeling in this very moment? _____
Rate your level of stress (minimal 0-10 high) 0 1 2 3 4 5 6 7 8 9 10
Describe in three words your emotional well-being 1._____ 2. _____ 3. _____

List and prioritize your current symptoms/issues/emotions (stress, pain, tension, numbness, tingling, swelling, feelings of hopelessness, overwhelmed, alone, lost or confused, etc.)
_____
_____
_____

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)?
Yes or No Please explain: _____
_____
List current medications and/or supplements: _____
_____

Are you wearing contacts? Yes No
Are you wearing dentures? Yes No
Are you wearing a hairpiece? Yes No
Are you pregnant? Yes No

Health History

Have you had any injuries, surgeries, traumas, or experiences in the past that may influence today's treatment?

_____

_____

Circle any of the following health conditions that you currently have:
Blood clot, infections, congestive heart failure, contagious diseases, pitted edema
Please answer honestly, as massage/bodywork may not be indicated for the above conditions.

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

Current	Past	Muscle or joint pain	_____
Current	Past	Muscle or joint stiffness	_____
Current	Past	Numbness or tingling	_____
Current	Past	Swelling	_____
Current	Past	Bruise easily	_____
Current	Past	Sensitive to touch/pressure	_____
Current	Past	High/low blood pressure	_____
Current	Past	Stroke, heart attack	_____
Current	Past	Varicose Veins	_____
Current	Past	Shortness of breath, asthma	_____
Current	Past	Cancer	_____
Current	Past	Neurological (MS, Parkinson's, chronic pain)	_____
Current	Past	Epilepsy, seizures	_____
Current	Past	Headaches, Migraines	_____
Current	Past	Dizziness, ringing in the ears	_____
Current	Past	Digestive conditions (Crohn's, IBS)	_____
Current	Past	Gas, bloating, constipation	_____
Current	Past	Kidney disease, infection	_____
Current	Past	Arthritis (rheumatoid, osteoarthritis)	_____
Current	Past	Scoliosis	_____
Current	Past	Broken bones	_____
Current	Past	Allergies	_____
Current	Past	Diabetes	_____
Current	Past	Endocrine/thyroid conditions	_____
Current	Past	Depression/anxiety	_____
Current	Past	Memory loss, confusion, concussion, easily overwhelmed	_____

Comments for your Therapist:

_____

_____

Initial:_____

Consent of Treatment

It is my choice to receive treatment at Trinity Wellness Center LLC. I have completed this form to the best of my knowledge. I have stated all medical conditions that I am aware of and I will update Trinity Wellness Center LLC of any changes to my health status.If I experience any pain or discomfort during the sessions, I will immediately inform the therapist so that the pressure and/or treatment 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 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 therapist 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 given should be construed as such. Because massage/bodywork should not performed under certain medical conditions, I affirm that I have stated in all my known medical conditions and 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 NO liability on the therapist's part should I fail to do so. I am fully aware of the risks involved and hazards connected with skin care treatments, and I voluntarily assume full responsibility for any risks of loss, property damage, or personal injury, that may be sustained by me, or any loss or damage to property owned by me as a result of being engaged in such an activity, whether caused by the negligence or otherwise. I also understand that any illicit or sexually suggestive remarks or advances made by me will result IMMEDIATE termination of the session, and I will be liable for FULL payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

I also understand and believe that the body has the ability to heal itself and, to do so, complete relaxation is often suggested. Long term imbalances in the body sometimes require multiple treatments to allow the body to reach the level of relaxation necessary to bring the system back into balance. I understand and acknowledge that self-improvements requires commitment on my part, and I must be willing to actively make positive changes if I am to receive the full benefits of my Therapeutic Sessions. I understanding all of this, and, I give my consent to receive care.

Client Signature: _____ Date: _____

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