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Confidentiality: Any information exchanged on this form or during a session is strictly confidiential. It will be used for the sole purpose of providing the best health care servcices possible.

FSA/HSA Accepted

Client Health Intake Form **Referred By:**_____

Name: _____Date of Birth_____

Address: _____City_____ State:_____ Zip:_____

Home Phone: #_____ Work/Cell #_____

E-mail:_____

Emergency Contact _____Relationship_____

Occupation:_____

Are you pregnant? Y__ N__

Are you currently under a physicians care for an acute or chronic condition? Y__ N__ If yes, please explain: _____

_____

Have you received a massage before? Y__ N__ If yes, when? _____

Any range of motion restrictions? _____

Please list the areas of tension, pain, or discomfort you wish to be addressed:_____

Health Information

- Please mark an (✓) by all current conditions and (X) for all past condttions

__ High/Low Blood Pressure

__Swelling/Edema

__Cardiac or Ciculatory issues

__Epilepsy/Seizures

__Osteoporiosis (bones that are weak or brittle)

__Arthritis

__Headaches/Migraines

__Allerrgies

__Skin Sensitivities (oils, lotion, pressure, etc)

__Numbnss or Tingling. Neuropathy

__Bursitis

__Tendonitis/Tendonosis

__Psoriasis

__Scoliosis

__Plantar Fascitis

__Neuropathy

__Thyroid Disease

__Hormone Imbalance

__Contageous Disease

__Torn ligament, tendon or muscle

Over the Past 5 years, have you had any of the following: Please Circle:

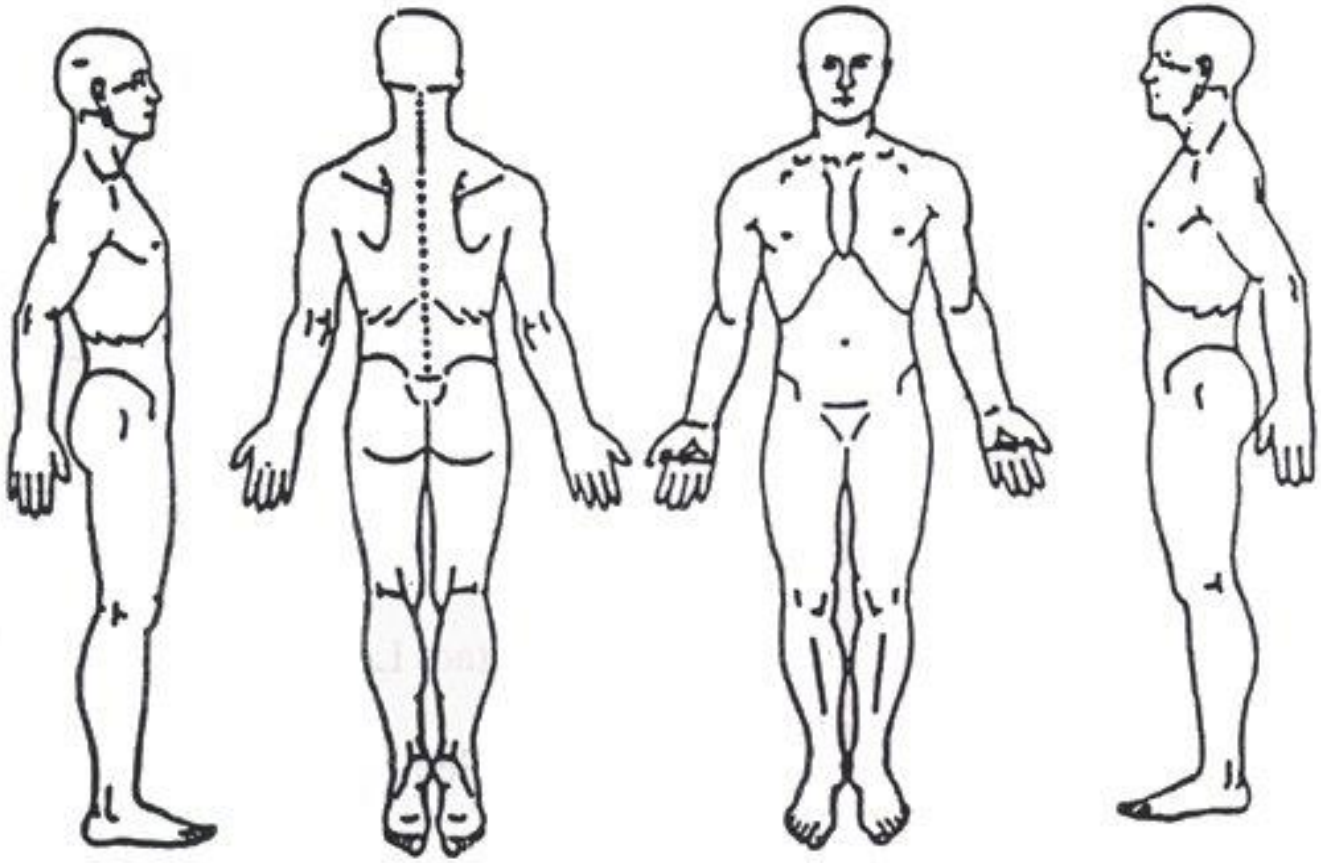
Falls Boken Bones Car Accidents Surgeries

Please List All Medications You Are Currently Taking

_____

_____

Please mark on the bodies below where you have had and are experiencing pain or discomfort. You may give a brief explanation below. *(Note: it is also helpful to mark previous injures you may have encountered at any time throughout your life which will help the practitioner give a better overall body evaluation.*



Right *Back* *Front* *Left*

_____

_____

_____

_____

_____

_____

_____

CLIENT CONSENT:

Bodywork therapy should not be performed under certain adverse conditions. I affirm that I have stated all my known physical condition and have 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 understand that Muscle Works Massage Therapy is a professional licensed and insured practice and is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness and that nothing said on the course of the session should be construed as such. I understand that I should see a physician, chiropractor or other qualified medical specialists for any mental or physical ailment that I am aware of. I understand that the practitioner will perform an initial assessment based on palpations, observation and the symptoms I described. If I experience any pain of discomfort at any time during a session, I will immediately inform the practitioner so that adjustments can be made to fit my comfort level. I understand that bodywork therapy is provided by licensed professional health practitioner and I consent to receive said treatment with the understanding that it is not sexual. The Therapist may end or deny treatment at any time for any sexual misconduct, advances, or any inappropriate or unacceptable behavior of any kind. If I am not able to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, text, or e-mail. I agree that I will pay for thee missed appointment if I fail to cancel 24 hours in advance. I give my consent for evaluation pictures to be taken when needed. These pictures are confidential and not to be used for public use without my verbal or written consent.

Client Signature

(Print)_____Signature_____Date_____

Therapist Signature _____Date_____