Body Sense Wellness Center, Inc.

Client Information

Client Name _____ **Date** _____

Address _____ City, State & Zip _____

Phone (Home)_____ (Work / Cell) _____

I prefer to receive appointment reminders via ❑ Voice Mail ❑ Text ❑ Email

Birthday _____ Age _____ Referred by _____

Occupation _____ Email _____

Emergency Contact _____ Phone _____

Current Health Information:

Are you generally in good health? ❑ Yes ❑ No **A**re you pregnant or nursing? ❑ Yes ❑ No

Exercise: ❑ regularly ❑ occasionally ❑ never / **S**tretching: ❑ regularly ❑ occasionally ❑ never

List sports/exercises/hobbies you do regularly: _____

Daily water intake: _____ 16 oz glasses

Indicate consumption:

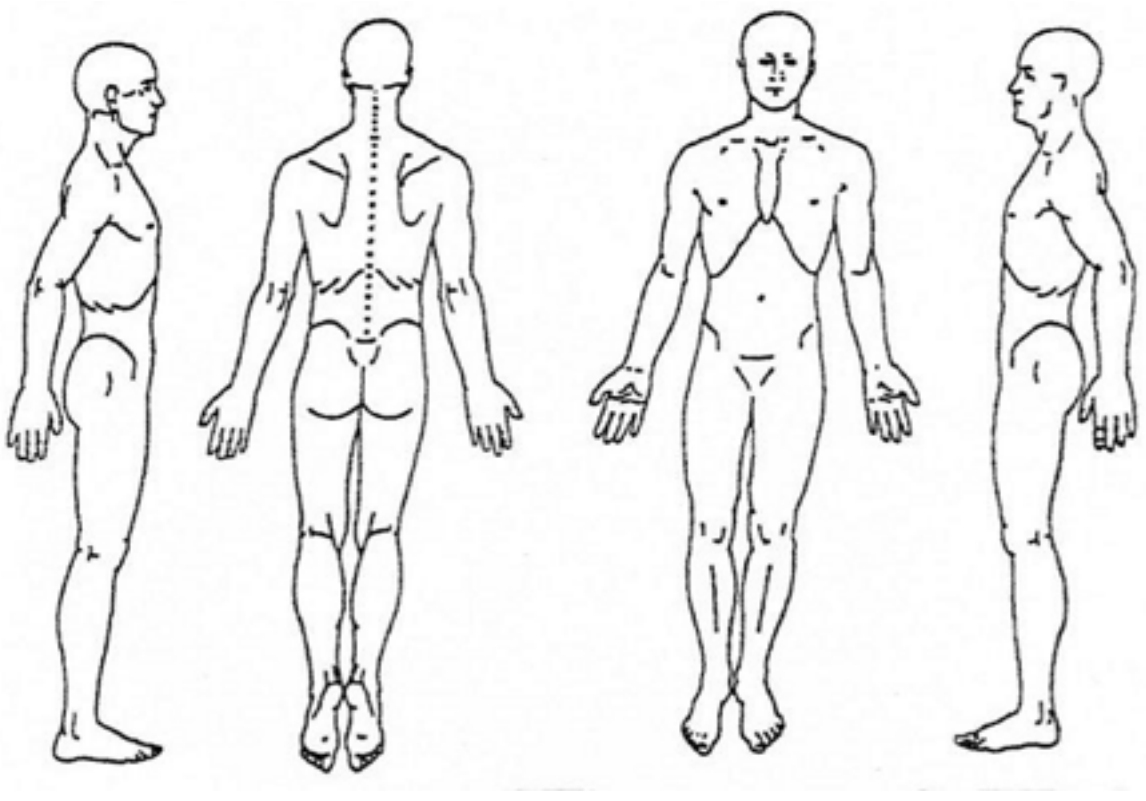
Caffeine	❑ None	❑ Light	❑ Moderate	❑ Heavy
Alcohol	❑ None	❑ Light	❑ Moderate	❑ Heavy
Nicotine	❑ None	❑ Light	❑ Moderate	❑ Heavy
Drugs	❑ None	❑ Light	❑ Moderate	❑ Heavy

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

Have you had previous professional massage / bodywork? ❑ Yes ❑ No

Are you currently in any pain? ❑ Yes ❑ No **I**f yes, is it: ❑ Light ❑ Moderate ❑ Severe ?

On the figures below, please circle any area needing attention today:



Right Left

What is your major complaint or condition you want to improve, i.e., what are your specific goals for today's treatment?

_____

_____

When did you first notice this condition? _____ **I**s it getting worse? ❑ Yes ❑ No

What activities, therapies or products improve this condition? _____

What activities, therapies or products aggravate this condition? _____

Does this condition interfere with: ❑ Sleep ❑ Work ❑ Daily routine ❑ N/A ?

***Indicate any that apply*:**

❑ contact lenses	❑ eyeglasses	❑ orthotics	❑ hearing aid
❑ pacemaker	❑ dental appliance	❑ breast implants	❑ hair piece / wig
❑ allergies _____	❑ Botox injections	❑ undiagnosed lumps	❑ other _____

Medications currently taking:

❑ antibiotics	❑ anti-coagulants	❑ anti-depressants	❑ anti-inflammatory
❑ anti-diuretic	❑ anti-stress	❑ beta blocker	❑ blood thinner
❑ bronchial dilator	❑ diuretic	❑ hormone replacement	❑ insulin
❑ muscle relaxant	❑ pain killers	❑ ulcer medication	❑ vitamins/supplements
❑ other _____			

Medical History: *(Check any that apply)*

❑ arthritis _____	❑ hepatitis	❑ PMS syndrome
❑ asthma	❑ high blood pressure	❑ psoriasis / eczema
❑ cancer _____	❑ HIV / AIDS	❑ sciatica
❑ carpal tunnel syndrome	❑ infectious conditions _____	❑ scoliosis
❑ chronic pain _____	❑ kidney ailments	❑ skin conditions _____
❑ diabetes, type 1/ type 2	❑ lung/respiratory ailments	❑ sports injury _____
❑ dizziness/vertigo	❑ lymphedema	❑ tendonitis _____
❑ epilepsy	❑ multiple sclerosis	❑ ticklish _____
❑ fainting	❑ muscular dystrophy	❑ TMJ syndrome
❑ fibromyalgia	❑ neck/spine injury _____	❑ tuberculosis
❑ headaches _____	❑ osteoporosis	❑ ulcers
❑ heart disease _____	❑ phlebitis	❑ varicose veins

List any hospitalizations, surgeries, bone fractures, joint replacements, accidents you have had, or conditions not listed above:

_____

_____

Are you presently under the care of a physician, chiropractor, physical therapist, psychotherapist or other health care practitioner? ❑ Yes ❑ No **M**ay I contact? ❑ Yes ❑ No

Name/Phone _____

Please read and sign:

I understand that massage therapy is for the purpose of stress reduction and/or relief from muscular tension/spasm; and that the therapist does not diagnose illness, disease, or any other physical or mental disorder, or prescribe medical treatment or perform spinal manipulations. Information exchanged during the session is educational in nature and intended to help me become more conscious of my own health status. I have reported all my existing medical conditions and agree to report any changes as they occur. I understand I have the right to refuse treatment at any time during the session. I consent to have therapeutic massage and do not hold the therapist liable for complications that may arise as a result of the massage.

Please note: If you have a specific medical condition or present specific symptoms, certain massage or bodywork techniques may be contraindicated. A referral from your primary care provider may be required prior to your session. When no referral is provided the therapist reserves the right to refuse treatment.

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____
(If client is under 18 years old)