Client Information Form

Client Contact Information

Name: ____ Date: ____/_____/_____

Date of Birth: _____/_____/_____ Height: __________ Weight: ________

Address: ____ Phone 1: ______________________ h w c

____ Phone 2: ______________________ h w c

Email: ____

Spouse/Life Partner: ____ Phone: _______________________

Emergency contact: ____ Phone: _______________________

Physician/Health-care Provider: _______________________________ Phone: _______________________

Manual Therapies Information

Have you received professional massage/bodywork before? Yes ☐ No ☐ How recently?____________

Have you received chiropractic adjustments before? Yes ☐ No ☐ How recently?____________

Have you received physical therapy before? Yes ☐ No ☐ How recently?____________

Have you received acupuncture/acupressure before? Yes ☐ No ☐ How recently?____________

Have you performed corrective exercises to correct posture? Yes ☐ No ☐ How recently?____________

Daily Life Information

Occupation: ____________________________________

Do you have kids? Y N If so, what age(s)? ____________________

Hobbies: ____

____

Physical activities: ____

____

What behaviors do exhibit on a regular basis?

__Sitting for more than 1hr straight __Repetitive typing/finger pressing

__Lifting more than 10lbs regularly __ Repetitive body bending/twisting

__Cradle the phone to one ear (R L) __Carry equipment/tools on your body

__Hold a child on one hip (R L) __Drive >1hr at a time or >2hrs daily

Other/Notes: ____

____

Referral Information

How did you hear about LMMT? ____

Medical Information – Please answer honestly, as therapies may not be indicated for some conditions.

Do you wear glasses/contacts? Yes ☐ No ☐ | Do you use topical hormone treatments? Yes ☐ No ☐

Do you wear dentures? Yes ☐ No ☐ | Are you pregnant? Yes ☐ No ☐ If so, how long? ______

Do you smoke anything? Yes ☐ No ☐ | Do you eat healthy foods/follow a diet? Yes ☐ No ☐

Do you drink alcohol? Yes ☐ No ☐ If so, what is the average amount?______________________________

List the medications/vitamins you currently take and why: ____

____

____

Circle any of the following health conditions that you have or have had (If you are unsure, please ask):

Current	Past	Muscle or joint pain	Current	Past	Muscle or joint stiffness
Current	Past	Numbness or tingling	Current	Past	Localized swelling
Current	Past	Bruise easily	Current	Past	Sensitivity to touch/pressure
Current	Past	High/Low blood pressure	Current	Past	Stroke, heart attack, pulmonary embolism
Current	Past	Congestive heart failure	Current	Past	Skin conditions
Current	Past	Varicose veins	Current	Past	Shortness of breath, asthma
Current	Past	Cancer	Current	Past	Neurological (e.g. MS, Parkinson's, chronic pain)
Current	Past	Epilepsy, seizures	Current	Past	Headaches, Migraines
Current	Past	Dizziness, ringing in the ears	Current	Past	Digestive conditions (e.g. Crohn's, IBS)
Current	Past	Gas, bloating, constipation	Current	Past	Bone spurs
Current	Past	Arthritis (rheumatoid, osteoarthritis)	Current	Past	Osteoporosis, degenerative spine/disk
Current	Past	Scoliosis/Lordosis/Kyphosis	Current	Past	Broken bones
Current	Past	Major strains/sprains	Current	Past	Allergies ______________________________
Current	Past	Diabetes	Current	Past	Endocrine/thyroid conditions
Current	Past	Depression, anxiety	Current	Past	Memory Loss, confusion, easily overwhelmed
Current	Past	TMJ Dysfunction/jaw trouble	Current	Past	Concussion/head injury
Current	Past	Cold feet or hands	Current	Past	HIV/AIDS
Current	Past	Deep vein thrombosis/blood clots	Current	Past	Lymphadema

Explanation(s): ____

____

____

Family history of any of above listed: ____

____

Please list any surgeries or major accidents/injuries with approximate dates: _________________________

____

____

____

Consent for Treatment

For Massage Therapy only: I understand that assessment by the Licensed Massage Therapist 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 adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said by the LMT should be construed as such.

For Massage Therapy & Chiropractic Care: If I experience any pain or discomfort during this session, I will immediately inform the practitioner(s) so that adjustments may be made to increase my level of comfort. Because massage and chiropractic treatments 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. Understanding all of this, I give my consent to receive care.

Client signature: ____ Date: ____________

Parent/guardian signature (in case of a minor): ______________________________ Date: ____________