Client Information & Health History

All information provided will be kept strictly confidential.

Client Contact Information

Client Name: _____ Date of Birth: ____ /____ /____ Gender: M / F
Address: _____
Phone: _____ Email: _____
What is your occupation: _____
How would you prefer to receive appointment reminders? text only ☐, email only ☐, either is fine ☐
How were you referred to my office? _____
Emergency contact name: _____ Phone: _____

Massage Information

Have you ever received professional massage/bodywork before? Yes ☐ No ☐
If yes, how recently? _____
What was the purpose of that session? _____
What kind of pressure do you prefer? Light ☐, Medium ☐, Firm
Are you wearing… contacts? Yes ☐ No ☐ | dentures? Yes ☐ No ☐ | a hairpiece? Yes ☐ No ☐
Female clients - are you pregnant? Yes ☐ No ☐. If yes, what trimester are you in? _____

Health History

Have you had any injuries or surgeries in the past that may influence today's or any future treatments?
_____
_____
_____

List the medications you currently take and the purpose of each: _____
_____
_____
_____

Mark any of the following health conditions that you currently have (if you are unsure, please ask and please answer honestly, as massage may not be indicated for the conditions below):
blood clots ☐, infections ☐, congestive heart failure ☐, contagious diseases ☐, pitted edema ☐

Circle "Current" or "Past" to indicate conditions that you have now or have had in the past. Explain in detail, including treatment received. Or write N/A for not applicable

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 (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 Kidney disease, infection _____
Current Past Arthritis (rheumatoid, osteoarthritis) _____
Current Past Osteoporosis, degenerative spine/disk _____
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, easily overwhelmed _____
Other unlisted condition(s): _____
_____
_____
_____

Consent for Treatment: 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/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 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 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.

Disclosure: Massage or any form of Manual Therapy provided by Mitchell Diaz, LMT; is not to be considered or interpreted as a medical treatment, a medical diagnosis, a medical treatment plan, or as a substitute form of therapy for any medical condition. If you have or suspect that you have sustained any type of injury or ailment, please see a medical Doctor prior to requesting or receiving any form of Massage/Manual Therapy. Conditions requiring medical diagnosis and/or physical rehabilitative treatment or exercises will be referred out.

Client Signature: _____ Date: _____

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