Sindecuse Health Center

Sports Medicine Clinic

Massage Therapy Client Information

CLIENT (Please print)

Name_____ WIN #_____

Date of birth (MM/DD/YY)_____ Occupation_____

Referred by_____ Phone (_____)_____

Primary Care Medical Provider_____ Phone (_____)_____

Emergency contact_____ Phone (_____)_____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage therapy may be contraindicated. A referral from your primary care medical provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? ☐ No ☐ Yes How recent?_____

What are your massage or bodywork goals?_____

What level of massage pressure do you prefer? ☐ light ☐ medium ☐ firm

Do you have tension or soreness in a specific area? ☐ No ☐ Yes Please specify_____

IF YOU ANSWER YES TO ANY OF THE FOLLOWING QUESTIONS, PLEASE EXPLAIN AS CLEARLY AS POSSIBLE IN THE COMMENT SECTION BELOW.

☐ Yes ☐ No Do you frequently suffer from stress?
☐ Yes ☐ No Do you have diabetes?
☐ Yes ☐ No Any broken bones in the past two years?
☐ Yes ☐ No Do you experience frequent headaches?
☐ Yes ☐ No Are you pregnant?
☐ Yes ☐ No Do you suffer from arthritis?
☐ Yes ☐ No Are you wearing contact lenses?
☐ Yes ☐ No Are you wearing dentures?
☐ Yes ☐ No Do you have high blood pressure?
☐ Yes ☐ No Are you taking high blood pressure medication?
☐ Yes ☐ No Do you suffer from epilepsy or seizures?
☐ Yes ☐ No Do you suffer from joint swelling?
☐ Yes ☐ No Do you have varicose veins?
☐ Yes ☐ No Do you have osteoporosis?
☐ Yes ☐ No Do you have any allergies?
☐ Yes ☐ No Do you have any contagious diseases?
☐ Yes ☐ No Any injuries in the past two years?
☐ Yes ☐ No Have you ever had surgery?
☐ Yes ☐ No Do you have cardiac or circulatory problems?
☐ Yes ☐ No Do you suffer from back pain?
☐ Yes ☐ No Do you suffer from fibromyalgia?
☐ Yes ☐ No Do you bruise easily?
☐ Yes ☐ No Do you have numbness or stabbing pain?
☐ Yes ☐ No Are you sensitive to touch/pressure in any area?
☐ Yes ☐ No Do you have other health conditions?
☐ Yes ☐ No Are you taking medications?

Explain any "yes" responses: _____

I understand that Sindecuse Health Center clinical staff will not be aware of the conditions indicated on this form. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that it is my responsibility to consult a physician, chiropractor, or other qualified medical provider for any mental or physical ailment of which I am aware. I understand that the massage I receive is provided for the purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session(s), I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that massage 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(s) should be construed as such. Because massage should not be performed under certain 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 health 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.

_____ _____

Client (or Guardian) Signature Date

_____ _____

Practitioner Signature Date