

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Occupation: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M F Contact Lenses? Y N # massages in past? \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Why do you want a massage? \_\_\_\_\_

Have you ever been in an auto accident? Y?N (Describe if yes): \_\_\_\_\_

List all the medications you currently take: \_\_\_\_\_

Who is your health care provider/MD? \_\_\_\_\_ Phone: \_\_\_\_\_

**Describe any surgeries, broken bones, major injuries or accidents below--include dates (use back if necessary)**

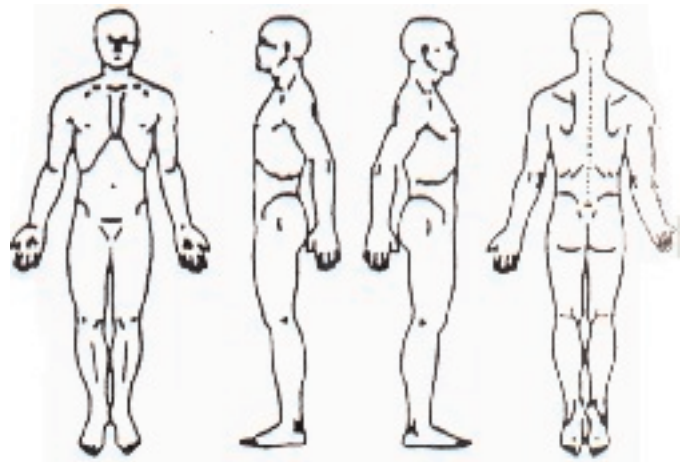
\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please check if you have had problems with any of the following:**

- |   |   |   |
|---|---|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Sinus/Allergies</li> <li><input type="checkbox"/> Numbness/Tingling</li> <li><input type="checkbox"/> Sciatica</li> <li><input type="checkbox"/> Skin conditions/rash where _____</li> <li><input type="checkbox"/> Infectious condition where _____</li> <li><input type="checkbox"/> Area of inflammation where _____</li> <li><input type="checkbox"/> Osteoporosis</li> <li><input type="checkbox"/> Seizures/Convulsions</li> <li><input type="checkbox"/> Dizziness/Fainting</li> <li><input type="checkbox"/> High/Low blood pressure</li> <li><input type="checkbox"/> Varicose veins</li> <li><input type="checkbox"/> Bruise easily</li> <li><input type="checkbox"/> Heart Condition</li> <li><input type="checkbox"/> Bursitis</li> <li><input type="checkbox"/> Arthritis</li> <li><input type="checkbox"/> Chest pain</li> <li><input type="checkbox"/> Shortness of breath</li> <li><input type="checkbox"/> Diabetes</li> </ul> | <p><b>HIPS, LEGS &amp; FEET:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Leg or foot cramps</li> <li><input type="checkbox"/> Feet feel cold</li> <li><input type="checkbox"/> Swollen ankles</li> <li><input type="checkbox"/> Ticklish feet</li> <li><input type="checkbox"/> Shooting pains</li> <li><input type="checkbox"/> Hip replacement</li> <li><input type="checkbox"/> Knee surgery</li> </ul> <p><b>SHOULDERS:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Can't raise arm                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Above shoulder</li> <li><input type="checkbox"/> Overhead</li> </ul> </li> </ul> <p><b>HEAD:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> TMJ</li> <li><input type="checkbox"/> Grind teeth</li> <li><input type="checkbox"/> Splint</li> <li><input type="checkbox"/> Headaches where _____</li> <li><input type="checkbox"/> Head feels heavy</li> <li><input type="checkbox"/> Loss of memory</li> <li><input type="checkbox"/> Lights bother eyes</li> <li><input type="checkbox"/> Ringing in ears</li> <li><input type="checkbox"/> Loss of balance</li> <li><input type="checkbox"/> Dizziness</li> </ul> | <p><b>ARMS &amp; HANDS:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Hands cold</li> <li><input type="checkbox"/> Loss of grip strength</li> <li><input type="checkbox"/> Shooting pains</li> </ul> <p><b>LOW BACK:</b></p> <p>Pain is worse when:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lifting</li> <li><input type="checkbox"/> Sitting</li> <li><input type="checkbox"/> Lying down</li> <li><input type="checkbox"/> Bending</li> <li><input type="checkbox"/> Coughing</li> <li><input type="checkbox"/> Working</li> </ul> <p><b>ABDOMEN:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Nausea</li> <li><input type="checkbox"/> Gas</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Tenderness</li> </ul> <p><b>FEMALES:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pregnant # of weeks _____</li> <li><input type="checkbox"/> Menstrual pain</li> <li><input type="checkbox"/> Irregular cycle</li> </ul> |
|---|---|---|

**Other conditions or information:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



(Please circle any areas of pain or injury)

**PLEASE READ BEFORE SIGNING:**

I understand that the massage I receive is provided for the basic purposes of relaxation and relief of muscular tension. If I experience any pain or discomfort during my sessions, 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 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 ailment that I am aware of. 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 sessions given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have listed all my known medical conditions and answered all questions honestly. I agree to keep my practitioners 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. If I have a specific medical condition or specific symptoms, massage may be contraindicated and a referral from my doctor may be required prior to service being provided. I understand that this clinic has a 24-hour cancellation policy and I will be liable for full payment for any appointments cancelled after this time. By signing below, I also authorize all employees and subcontractors of Boulder Therapeutics, Inc. to discuss and correspond about my medical status as it pertains to providing me with safe and effective massage therapy.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_