Integrative Massage of Boulder — Client Information Form

(All information will be kept confidential)

Name_____ Date of Birth _____

Address_____ City _____ State _____ Zip _____

Phone _____ Cell Phone _____ e-mail address _____

Occupation_____

Primary Care Physician_____ Phone _____

What are the results that you hope to experience from this massage session?

How did you hear about us?

Are you interested in receiving periodic newsletters and special offers? Y/N

Please list all medications that you currently take:

Please list any accidents, injuries, surgeries or hospitalizations in the past 5 years:

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

- ☐ Sinus/Allergies
- ☐ Numbness/Tingling
- ☐ Sciatica
- ☐ Skin conditions/rash where_____
- ☐ Infectious condition where_____
- ☐ Area of inflammation where_____
- ☐ Osteoporosis
- ☐ Seizures/Convulsions
- ☐ Dizziness/Fainting
- ☐ High/Low blood pressure
- ☐ Varicose veins
- ☐ Bruise easily
- ☐ Heart Condition
- ☐ Bursitis
- ☐ Arthritis
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Diabetes

NECK:

- ☐ Pain with movement
- ☐ Stiff Neck
- ☐ Grinding/Popping

HIPS, LEGS & FEET:

- ☐ Leg or foot cramps
- ☐ Feet feel cold
- ☐ Swollen ankles
- ☐ Ticklish feet
- ☐ Shooting pains
- ☐ Hip replacement
- ☐ Knee surgery

SHOULDERS:

- ☐ Can't raise arm
  - ☐ Above shoulder
  - ☐ Overhead

HEAD:

- ☐ TMJ
- ☐ Grind teeth
- ☐ Splint
- ☐ Headaches where_____
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Lights bother eyes
- ☐ Ringing in ears
- ☐ Loss of balance
- ☐ Dizziness

ARMS & HANDS:

- ☐ Hands cold
- ☐ Loss of grip strength
- ☐ Shooting pains

LOW BACK:

Pain is worse when:

- ☐ Lifting
- ☐ Sitting
- ☐ Lying down
- ☐ Bending
- ☐ Coughing
- ☐ Working

ABDOMEN:

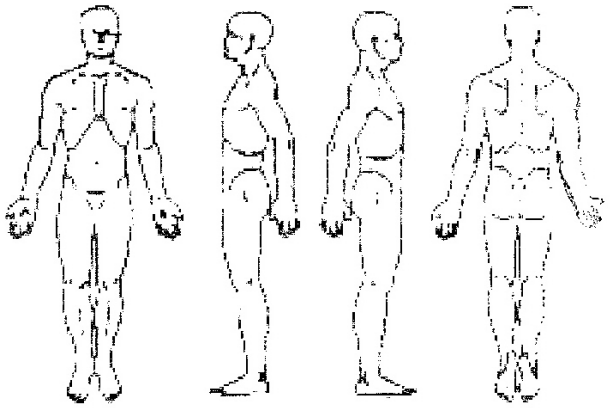
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Tenderness

FEMALES:

- ☐ Pregnant # of weeks_____
- ☐ Menstrual pain
- ☐ Irregular cycle

Other conditions or information:

_____
_____
_____
_____
_____
_____
_____



(Please circle any areas of pain or injury)

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 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. 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 Integrative Massage of Boulder has a 24-hour cancellation policy and I will be liable for full payment for any appointments canceled after this time.

Client's Signature_____ Date_____