Center for Clinical Massage 22672 Lambert St. suite 601, Lake Forest, CA 92630 (949) 510-4946

MASSAGE CLIENT INFORMATION

PLEASE PRINT LEGIBLY AND FILL IN ALL THE BLANKS

Initial Appointment date: _____

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Work: (_____) _____ Cell (_____) _____

Email (office use only) _____

Occupation: _____

Date of Birth: _____ Height: _____ Weight: _____ Gender: _____

How did you hear about us, Referred by? _____

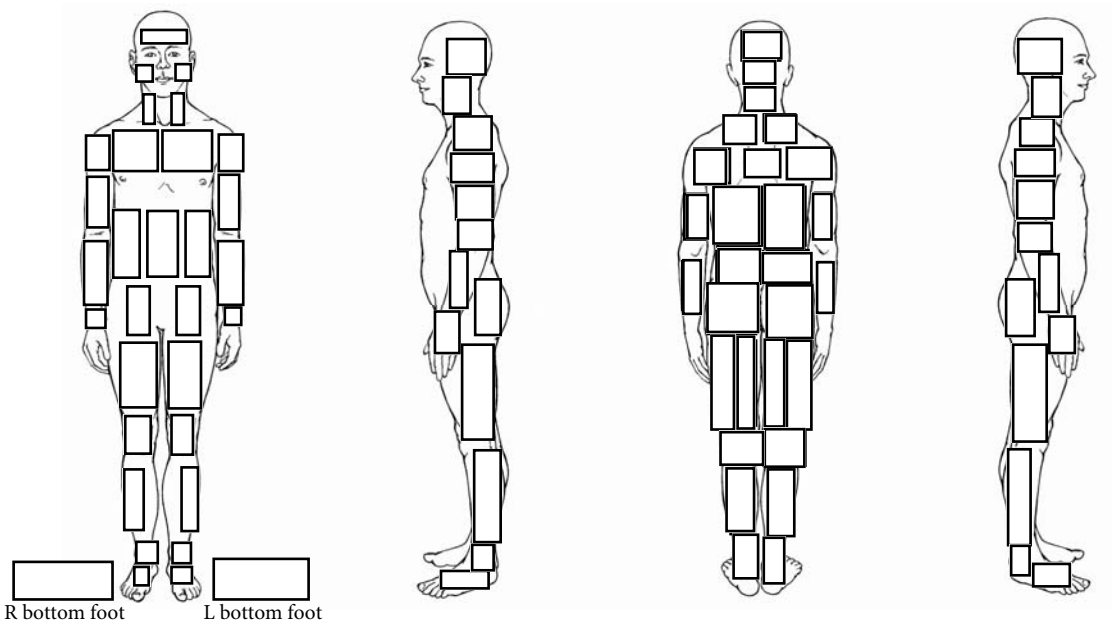
What is your reason for coming to see us today? _____

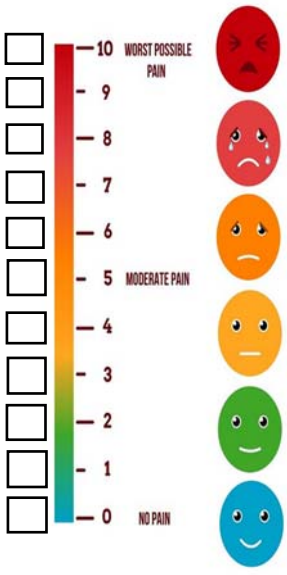
Where exactly is the area of discomfort? _____

Emergency Contact: _____ Phone: _____

Click on the figure below to specify your pain and tight areas.
Rate the recent level of pain (by putting a check mark next to the chart 1 – 10)
Has it been getting ☐Better or ☐Worse?

What does your discomfort feel like? ☐aching ☐cramping ☐dull ☐sore ☐deep ☐sharp ☐shooting ☐stabbing ☐sting ☐tingling ☐burning ☐numbness ☐radiating





HEALTH HISTORY

General

Current past comments

- ☐ ☐ headaches_____
- ☐ ☐ migraines_____
- ☐ ☐ fatigue_____
- ☐ ☐ infections_____
- ☐ ☐ fever_____
- ☐ ☐ sinus_____
- ☐ ☐ other_____

Muscles and Joints

Current past comments

- ☐ ☐ rheumatoid arthritis____
- ☐ ☐ osteoarthritis_____
- ☐ ☐ scoliosis_____
- ☐ ☐ bone fracture_____
- ☐ ☐ broken bones_____
- ☐ ☐ spinal problems_____
- ☐ ☐ disk problems_____
- ☐ ☐ bursitis_____
- ☐ ☐ joint pain_____
- ☐ ☐ TMJ, jaw pain_____
- ☐ ☐ spasms, cramps_____
- ☐ ☐ sprains, strains_____
- ☐ ☐ tendonitis_____
- ☐ ☐ muscle stiffness_____
- ☐ ☐ swelling_____
- ☐ ☐ inflammation_____
- ☐ ☐ neck pain_____
- ☐ ☐ shoulder pain_____
- ☐ ☐ arm pain_____
- ☐ ☐ low back pain_____
- ☐ ☐ hip pain_____
- ☐ ☐ leg pain_____
- ☐ ☐ other_____

Skin Conditions

Current past comments

- ☐ ☐ rashes_____
- ☐ ☐ athlete's foot, warts___
- ☐ ☐ other_____

Endocrine System

Current past comments

- ☐ ☐ thyroid_____
- ☐ ☐ diabetes_____

Reproductive System

Current past comments

- ☐ ☐ pregnancy_____
- ☐ ☐ painful emotional menses

Cancer/Tumors

Current past comments

- ☐ ☐ benign_____
- ☐ ☐ malignant_____

Nervous System

Current past comments

- ☐ ☐ sensitive to pressure___
- ☐ ☐ dizziness_____
- ☐ ☐ ringing in ears_____
- ☐ ☐ numbness, tingling____
- ☐ ☐ sciatica, shooting pain__
- ☐ ☐ chronic pain_____
- ☐ ☐ depression_____
- ☐ ☐ other_____

Allergies

Current past comments

- ☐ ☐ scents, oils, lotions____
- ☐ ☐ detergents_____
- ☐ ☐ other_____

Respiratory, Cardiovascular

Current past comments

- ☐ ☐ heart disease_____
- ☐ ☐ blood clots_____
- ☐ ☐ stroke_____
- ☐ ☐ lymphedema_____
- ☐ ☐ high, low blood pressure
- ☐ ☐ irregular heart beat____
- ☐ ☐ poor circulation_____
- ☐ ☐ pacemaker_____
- ☐ ☐ varicose veins_____
- ☐ ☐ chest pain, shortness of breath
- ☐ ☐ asthma_____

Digestive/Elimination System

Current past comments

- ☐ ☐ bowl problems_____
- ☐ ☐ gas/bloating_____
- ☐ ☐ bladder,kidney,prostate
- ☐ ☐ abdominal pain_____
- ☐ ☐ other_____

Habits

Current past comments

- ☐ ☐ tobacco_____
- ☐ ☐ alcohol_____
- ☐ ☐ coffee, soda_____
- ☐ ☐ other_____

LOW LEVEL LASER, ULTRASOUND, and (DMS) DEEP MUSCLE STIMULATOR, RAPID RELEASE		
YES	**NO**	**CONTRAINDICATIONS**
☐	☐	Have you had/have cancer (tumors or cancerous areas)?
☐	☐	Do you have any photo sensitivities?
☐	☐	Are you currently pregnant or nursing?
☐	☐	Do you have a pacemaker?
☐	☐	Are you taking any - Immune suppressive drugs?
☐	☐	Are you taking any - Anticoagulants?
☐	☐	Are you taking any - Anti-inflammatory medications?
☐	☐	Have you had a cortisone or Botox shot in the last 30 days?
☐	☐	Do you have any bones that are fractured at the moment? How long ago?
☐	☐	Have you had surgery that added pins, screws, plates, or anything else?

INFORMATION ABOUT THE AREA OF DISCOMFORT

What were you doing that created the discomfort? _____

When did the injury or discomfort happen? _____

Have you had the same injury or discomfort before? _____

Was the onset (Sudden or Gradual)? _____

What movements were you doing at the time of injury? _____

How often does it bother you (constantly, daily, weekly, monthly)?_____

How long does it last once you start feeling the discomfort?_____

What specifically makes it worse? (Certain movements/activities, stress, time of day, resting, no pattern)

Explain:_____

What makes it feel better? (Certain movements/activities, heat/ice, time of day, therapies, resting, nothing helps)

Explain:_____

Have you tried other therapies/remedies? ☐ Yes ☐ No and did they help? ☐ Yes ☐ No

Explain:_____

Have you ever had a surgery? ☐ Yes ☐ No and was the surgery successful? ☐ Yes ☐ No

Explain:_____

List any other health problems for which you are being treated to help me with a massage strategy:

_____

Current Medications: (including aspirin, ibuprofen, etc.) This will help me know what techniques to use.

_____

MASSAGE INFORMATION

How much pressure do you prefer with massage? ☐ Light ☐ Medium ☐ Firm pressure

Is there a type of massage that you prefer: _____

Do you want a full body massage or do you want me to focus on the injury site and muscles that will affect the injury? ☐ Full body massage ☐ Muscles affecting the Injury Site

ACTIVITIES OF DAILY LIVING

In this section, the idea is to get a sense of what type of movements and to what intensity and frequency of activities/movements, postures/positions, and exercise you get on a regular basis.

Do these symptoms interfere with your activities of daily living (sleep, exercise, work, etc.)? ☐ Yes ☐ No

Explain: _____

Job/Work Duties: _____

Household Duties: _____

Regular Activities/Hobbies: _____

Exercise: _____

Sleeping Position: _____

Do you have difficulty sleeping on your: stomach ☐ back ☐ side ☐

Do you believe it is possible to heal 100%? If not, what percentage? _____

How long do you feel it will take? _____

The level of stress you are experiencing on a regular basis, on a scale of 1 to 10. _____

(1 being the lowest): (mild 1-3, moderate 4-7, severe 8 – 10)

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 (DMS) deep muscle stimulator, and Rapid Release given here is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation and energy flow. 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. Understanding all of this, I give my consent to receive care.

Printed Name_____ Date_____

Signature_____

Signature (Guardian if under 18) _____