



SOMATAPOINTS

THERAPEUTIC MASSAGE, LC

Confidential Client Information

NEUROVASCULAR THERAPY

Name: _____ Date: _____

Phone W: () _____ Phone H: () _____ Cell: () _____

Address: _____ City: _____ State: _____ Zip: _____

Email address: _____ *email only for office use* *opt out*

Local contact Information (if different): _____ Telephone: () _____

Date of Birth: ____/____/____ Height: _____ Weight: _____ male female

Occupation: _____ Referred by: _____

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/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

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

If you answer "yes" to any of the following questions, please explain as clearly as possible.

Yes No Do you frequently suffer from stress?

Yes No Do you have diabetes?

Yes No Do you experience frequent headaches?

Yes No Are you pregnant?

Yes No Do you frequently 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 If yes to previous question, are you taking medication for this?

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 any contagious diseases?

Yes No Do you have osteoporosis?

Yes No Do you have any allergies?

Yes No Do you bruise easily?

Yes No Have you had any broken bones in the past two years?

Yes No Have you been in an accident or suffered any injuries in the past two years?

Yes No Do you have tension or soreness in a specific area
Please specify in lined area below

Yes No Do you have cardiac or circulatory problems?

Yes No Do you suffer from back pain?

Yes No Do you have numbness or stabbing pains anywhere?

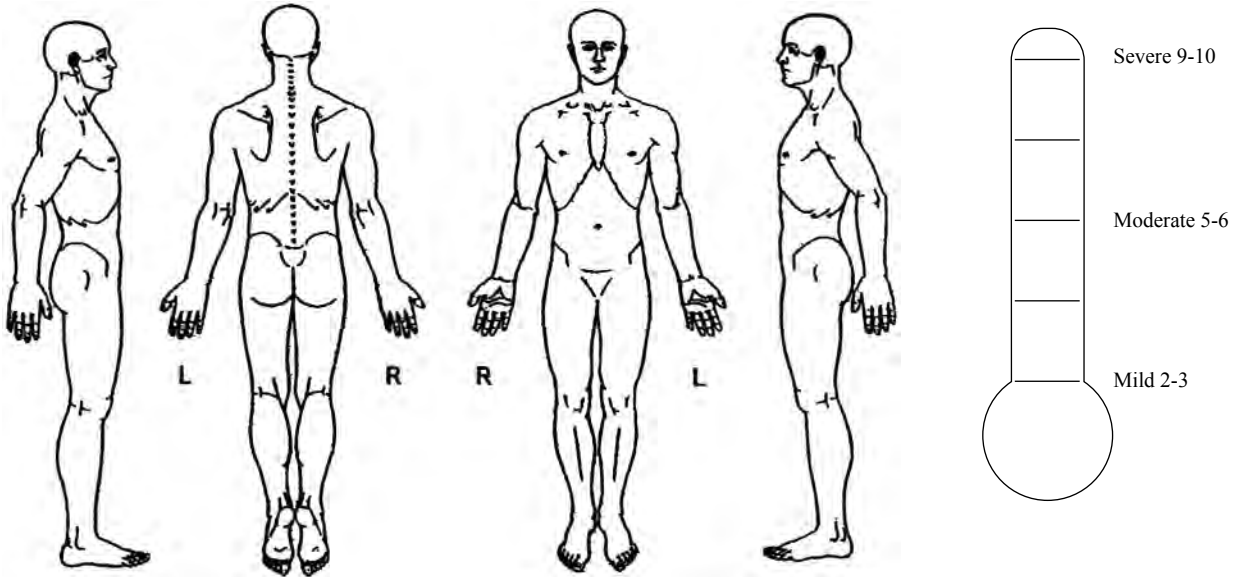
Yes No Are you very sensitive to touch or pressure in any area?

Yes No Have you ever had surgery? Explain below.

Yes No Do you have any other medical condition or are you taking any medications I should know about? If so, explain below.

What is your reason for coming today? _____

Where exactly is the problem? Mark the figure below to specify. Rate the level of pain by shading the thermometer below. Has the pain been getting better or worse? (circle one)



Describe the pain and how it feels: (aching, cramping, dull sore, deep, sharp, shooting, stabbing, stinging, tingling, burning, numbness, radiating - if so, where? _____

How did it start the first time? (sudden or gradual onset, and mechanism of injury) _____

How often does it bother you? (Constant all the time, everyday, ___ x per week, ___ x per month)

How long does it last once it is there? (Always there, ___ minutes/hours, no pattern)

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

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

Do you have a diagnosis from a Doctor? If yes, list it and the Doctor. _____

Other therapies/remedies tried and results: _____

Have you ever had any surgeries and were they beneficial at the time? _____

List any other health problems for which you are being treated: _____

Current medications: _____

AGREEMENT

I understand that a 24-hour notice for a change or cancellation of appointment is necessary. I agree to arrive on time to receive the full benefit of my appointment. If I am late or do not show for an appointment, I agree to pay for the appointment, unless held up due to an emergency. I understand that the massage therapist does not diagnose or prescribe illness or disease. I further understand that massage therapy is for the purpose of reduction of stress, muscular spasm or pain, and improved circulation, energy, and sense of well-being.

Client Signature _____ Date _____