MEDICAL MASSAGE CINCINNATI

(W)HOLISTIC APPROACH TO LIVING

Name: _____ Date: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Occupation: _____ Work Phone: _____

Date of Birth: _____ Email: _____

Emergency Contact: _____ Phone: _____

Referred by: _____

Are you interested in Bodywork Yes☐No☐ Are you interested in Nutrition Yes☐No☐ Are you interested in Wellness Coaching Yes☐No☐

Health History

Are you experiencing any of the following:

- ☐ Cold/Flu
- ☐ Fever
- ☐ Infections
- ☐ Contagious Conditions
- ☐ Burns/Sunburns
- ☐ Skin Conditions (i.e. Warts)
- ☐ Cuts/Bruises
- ☐ Numbness/Tingling
- ☐ Piercing or stabbing Pain
- ☐ Frequent Headaches
- ☐ Back Pain
- ☐ Arthritis
- ☐ Joint Swelling
- ☐ Tendonitis
- ☐ Depression/Anxiety
- ☐ Muscular/Skeleton Disorders
- ☐ New Tattoos/Piercings
- ☐ Digestive Disorders
- ☐ Possible or Definite Pregnancy
- ☐ Other_____

Have you ever been diagnosed with, or been advised to seek treatment for any of the following:

- ☐ High/Low Blood Pressure
- ☐ Stroke/ TIA's
- ☐ Diabetes/Hypoglycemia
- ☐ Heart Disease
- ☐ Aneurysm
- ☐ Anemia /Blood Disorders
- ☐ Blood Clots/Phlebitis
- ☐ Other Circulatory Conditions
- ☐ Varicose Veins
- ☐ Bruising easily
- ☐ Lymphatic conditions
- ☐ Kidney/Bladder Conditions
- ☐ Liver/Gall Bladder Conditions
- ☐ Cancer
- ☐ Reproductive Organ Conditions
- ☐ Allergies
- ☐ Osteoporosis
- ☐ Disc Disorder
- ☐ Neuritis/ Nerve Disorders
- ☐ Seizure Disorders (Epilepsy)
- ☐ Asthma
- ☐ Chronic Respiratory Conditions
- ☐ Chronic Sinus Conditions

Are you currently:

Taking any medications? Yes☐ No☐ If yes please list: _____

_____

_____

_____

_____

Taking any supplements, herbs, or OTC medicines? Yes☐ No☐ If yes please list: _____

_____

_____

_____

_____

Wearing contacts? Yes☐ No☐ _____

Wearing any prosthetics? (Including dentures) Yes☐ No☐ _____

Have you had any:

Hospitalization/Surgeries? Yes☐ No☐ If yes please list: _____

_____

_____

_____

_____

Accidents or Injuries? Yes☐ No☐ If yes please list: _____

_____

_____

_____

_____

Broken or dislocated bones? Yes☐ No☐ If yes please list: _____

_____

_____

_____

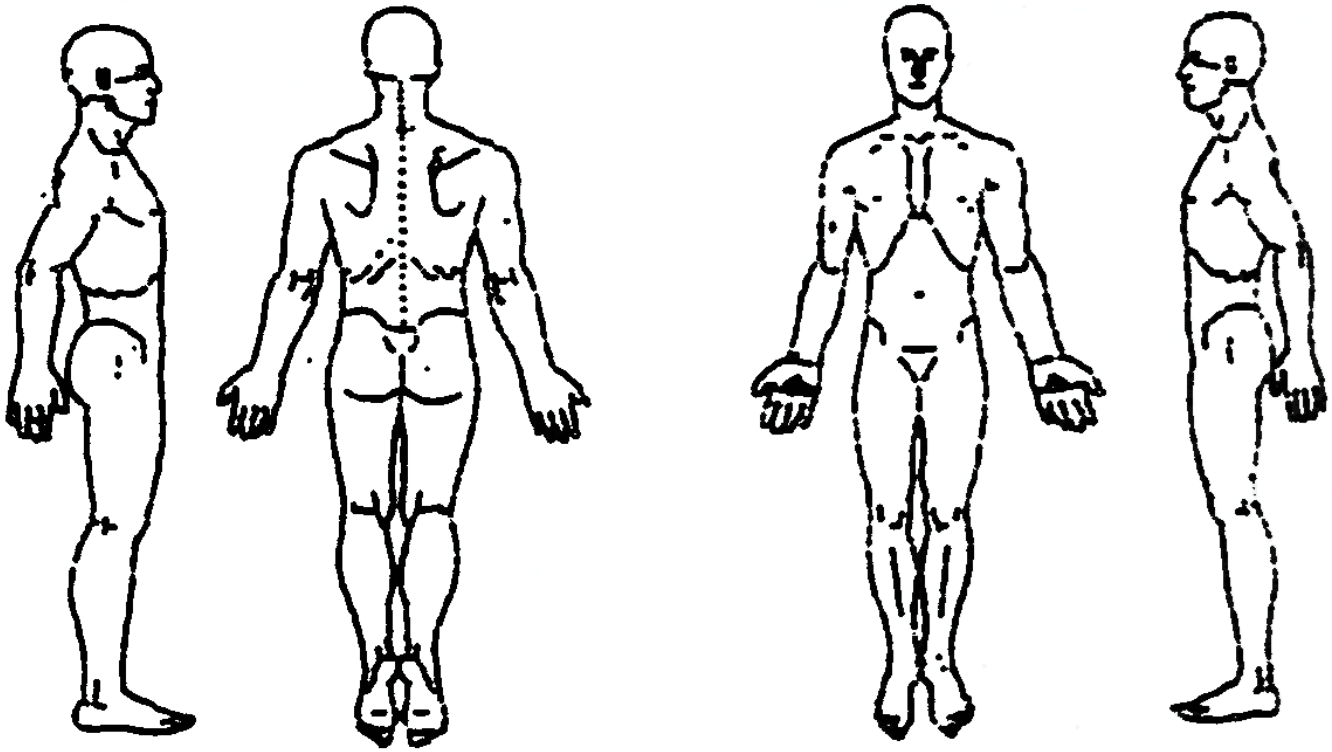
_____

Have you experienced professional massage or bodywork? Yes☐ No☐ If yes, how recently? _____

If we will be working as a Nutrition Client, please skip to form #2

If we will be working on Holistic Wellness and stress skip to form #3

Please describe how you are feeling today, and note any places of tension, pain, discomfort, etc. on the diagram below:



Comments: _____

_____

_____

_____

_____

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_____

Waiver and Release

I_____, understand that massage is provided for the basic purpose of relaxation, stress reduction and relief of muscular tension. 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.

Massage/Manual therapies services are not meant to take the place of a physician's care. Information exchanged during a massage is educational in nature, not diagnostic or prescriptive, and is to be used at my own discretion. Because massage should not be performed relative to certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I understand that it is my responsibility to keep the massage therapist updated as to any changes in my medical profile.

I understand all guidance received is for general purposes and medical advice will be obtained from your primary care provider only.
* Nutrition and exercise are intended to promote general health and wellness and are not intended to replace physician care or medical intervention. All nutritional assessment, suggestions and consultation on nutrition, diet and exercise are based on your input, and are not intended to diagnose, treat or cure any disease or ailment.
*You accept all responsibility for reviewing diet, nutrition, lifestyle or exercise suggestions with a licensed medical professional before following said suggestions.
You agree to inquire about any activities with which you are not familiar, and provide any information which may limit your participation in suggested activities.
* Results and changes in your general health and wellness may vary depending on medical conditions, medications, and accuracy in following suggested guidelines.

* As your general health and wellness may change with modifications in diet, nutrition and lifestyle, physician prescribed medications may require modification. It is your responsibility to discuss this with your physician. Never reduce or eliminate physician prescribed medications without the direction of your physician or medical care provider.
* Your personal and health information will remain confidential and will not be shared without your consent.
* You give permission for the information provided on this form and discussed in your nutritional consultation(s) to be shared and discussed with the primary care physician you have listed on this form, at the discretion of the clinical nutritionist and in the interest of your general health and wellness.

I hereby waive and release my massage therapist, Medical Massage Cincinnati, LLC. and anyone affiliated with it, from any and all liability, past, present and future, relating to massage/manual therapy and body work.

Signature: _____ Date: _____

If Client is a minor, under 18 years of age:

By my signature below I hereby authorize Medical Massage Cincinnati, LLC. to perform massage/manual therapy techniques to my child or dependent: _____, as they deem necessary.

Signature of Parent/Guardian: _____