



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

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

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

Are you currently:

Taking any medications?YesNoIf yes please list:

Taking any supplements, herbs, or OTC medicines?YesNoIf yes please list:

Wearing contacts?YesNo

Wearing any prosthetics? (Including dentures)YesNo

Have you had any:

Hospitalization/Surgeries?YesNoIf yes please list:

Accidents or Injuries? Yes No If yes please list:

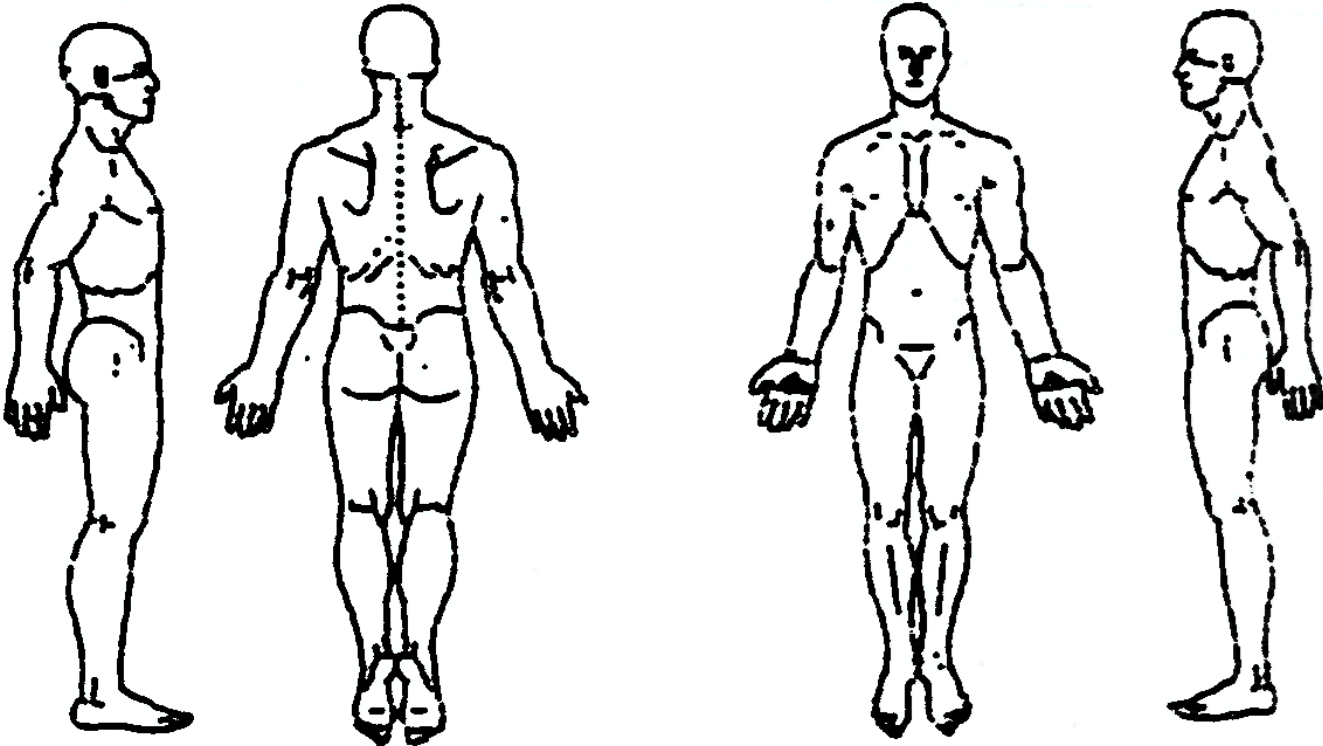
Broken or dislocated bones? Yes No If yes please list:

Have you experienced professional massage or bodywork?YesNoIf 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: _____

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. DBA as (W)Holistic Approach to Living and anyone affiliated with it, from any and all liability, past, present and future, relating to massage/manual therapy and body work.

Cancellation Policy:

I understand that appointments require advance preparation and hold a dedicated space in Suzanne's schedule. Cancellations or rescheduling requests made less than 24 hours before the scheduled appointment time will be subject to a cancellation fee of \$50 for standard sessions, or \$150 for Reset Intensive sessions. This fee will be charged to the card on file or invoiced prior to the next scheduled session.

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: _____