WELLNESS CENTER of Plymouth

Client Information

Name _____ ❑ Male ❑ Female DOB_____

Address _____ City _____ State _____ Zip _____

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

E-mail _____ Married ❑ **Y** ❑ **N** Anniversary _____ Children_____

Occupation _____ Physician _____

Referred by _____ Phone ( ) _____

Emergency Contact _____ Phone ( ) _____

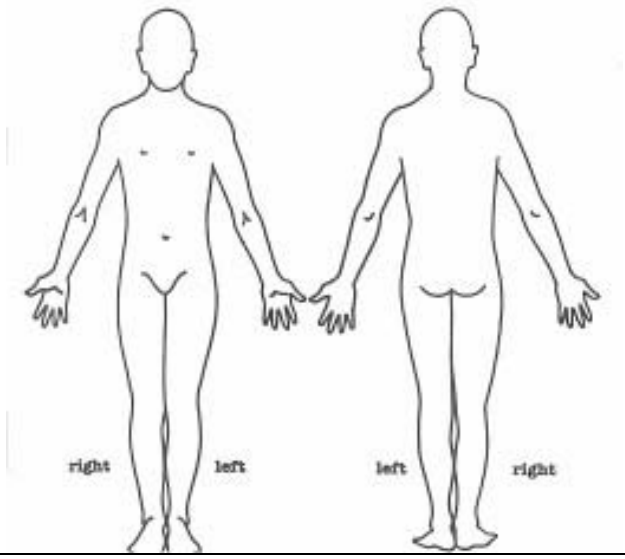
Please take a moment to carefully read and fill out the following information. This information helps us better serve your needs here at the Wellness Center of Plymouth.

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

What are your massage goals? _____

What kind of pressure do you prefer? ❑ light ❑ medium ❑ firm Focus areas _____

Use the key below to mark your current or recent symptoms of discomfort, stiffness, and/or pain on the diagrams: (Scale of 0 to 10 with 10 = worst level)

Use the following symbols to mark on the diagram		**Are the symptoms:**
○ = Circle areas of **discomfort** ✘ = Joint and muscle **stiffness** ● = Active **pain**		❑ Constant Areas_____ ❑ Comes and goes Areas_____ ❑ Getting worse Areas_____ ❑ Improving Areas_____ ❑ Same Areas_____ ❑ Other_____

CLIENT INFORMATION

NOW	PAST	**Please "X" if applicable and specify as clearly as possible where requested.**
		Frequently affected by stress or anxiety?
		Sensitive to touch or pressure in any areas? *Please specify*_____
		Bruise easily?
		Numbness or tingling in any areas? *Please specify*_____
		Headaches? *Frequency*_____
		Pain or swelling in joints? *Please specify*_____
		Broken bones (last two years)? *Please specify*_____
		Surgeries? *Please specify*_____
		Medical conditions? *Please specify*_____
		Medications? *Please specify*_____
		Arthritis? P*lease specify*_____
		Osteoporosis or bone disorders? *Please specify*_____
		Cardiac or circulatory problems? *Please specify*_____
		High blood pressure? *Medication(s)*_____
		Varicose veins? *Please specify*_____
		Diabetes? *Please specify*_____
		Allergies? *Please specify*_____
		Epilepsy or seizures? *Please specify*_____
		Contagious diseases? *Please specify*_____
		Pregnant? Weeks?_____ (Note from OB/GYN required)
		Cancer? *Please specify*_____

Comments _____

_____

If you have a specific medical condition or specific symptoms, massage may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

I understand that the massage I receive is provided for the basic purpose of relaxation 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. 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 mental or physical ailment of which I am aware. 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 session given should be construed as such. Because massage 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. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

I understand that 24 hours' notice is necessary for any change or cancellation of an appointment. Less than a 24 hour notice will result in a $35 cancellation fee or the cost of the service (whichever is less) being charged to my account or credit card on file.

Client Signature _____ Name (Printed) _____ Date _____

Therapist Signature _____ Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Name (Printed)_____ Date _____