Client Intake Form

Name _____ Phone (_____) _____ DOB _____

Address _____ City _____ State _____ Zip _____

E-mail: _____

Referred by: _____ Phone (_____) _____

In case of emergency: _____ Phone (_____) _____

Occupation _____ ❑ Male ❑ Female Physician _____

Health Insurance Carrier _____

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.

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

What are your massage or bodywork goals? _____

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

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 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 Are you taking high blood pressure medication?
❑ 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 Any broken bones in the past two years?
❑ Yes ❑ No Any injuries in the past two years?
❑ Yes ❑ No Do you have tension or soreness in a specific area?
Please specify _____
_____
❑ 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?
❑ Yes ❑ No Are you sensitive to touch or pressure in any area?
❑ Yes ❑ No Have you ever had surgery? Explain below.
❑ Yes ❑ No Other medical condition, or are you taking any medications I should know about?
Comments _____
_____

I understand that the massage/bodywork 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 or 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 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. 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.

Client Signature _____ Date _____

Practitioner Signature _____ Date _____

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

Signature of Parent or Guardian _____ Date _____

Manual Therapist

WELLNESS CHART

Name _____ ID#/DOB _____ Date _____

Phone _____ Address _____

1. What are your goals for health, and how may I assist you in achieving your goals? _____

2. List typical daily activities—work, exercise, home. _____

3. Are you currently experiencing any of the following? If yes, please explain.

pain, tenderness	☐ No ☐ Yes: _____		stiffness	☐ No ☐ Yes: _____	
numbness or tingling	☐ No ☐ Yes: _____		swelling	☐ No ☐ Yes: _____	
allergies	☐ No ☐ Yes: _____				

4. List all illnesses, injuries, and health concerns you have now or have had in the past 3 years. (Examples: arthritis, diabetes, car crash, pregnancy) _____

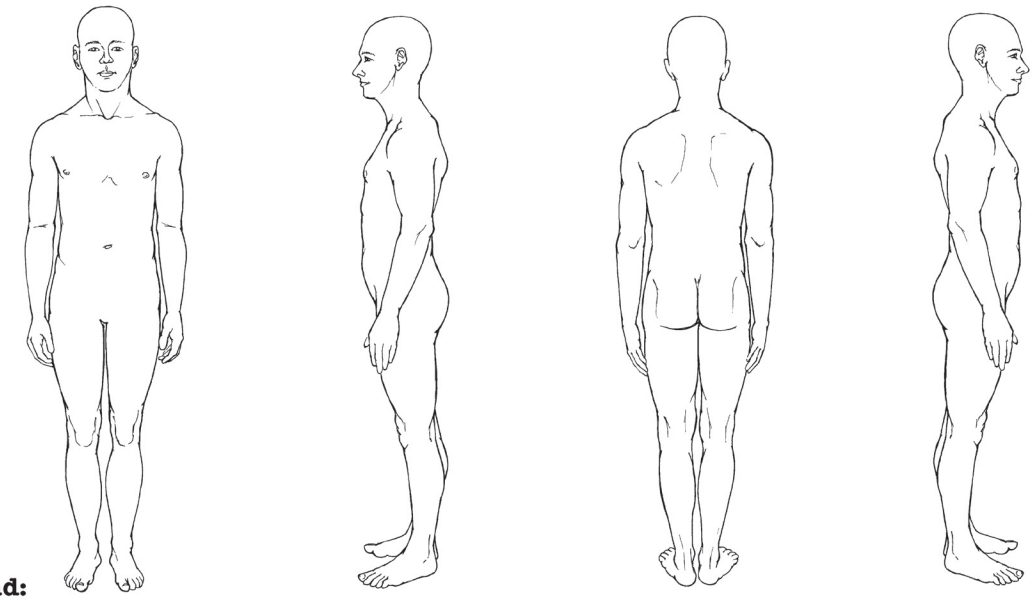
5. List medications and pain relievers taken this week. _____

6. I have provided all my known medical information. I acknowledge that massage therapy is not a substitute for medical diagnosis and treatment. I give my consent to receive treatment.

Signature _____ Date _____

Tx: _____

C: _____



Legend:

TP	TeP	Ⓟ	Infl	HT	SP	initials _____
Adh	Numb	rot	elev	Short	Long	

Informed Consent Cupping and FasciaBlaster™ Release Therapy

Cupping bodywork therapy is an adaptation of an ancient technique; the purpose of this technique is to promote health and healing by: loosening soft tissue and connective tissue, scarring and adhesions moving stagnation and increasing lymphatic flow and circulation. This therapy utilizes silicone or plastic cups and a vacuum pistol to create suction on the body surface. These cups are moved over the skin using gliding, shaking, popping and rotating techniques while gently pulling up on the cup, or may be parked for a short time to facilitate joint mobilization or soft tissue release. Suction reaches deep into the soft tissue, attachments and organs. Another benefit is to pull toxins and inflammation from the body to the surface of the skin where the lymphatic system can more readily eliminate them. Potential reactions to Cupping are temporary and may include:

- Cup Kiss: discoloration due to toxins and old blood being brought to the surface Post tenderness: usually less than experienced from deep tissue work
- Redness and Itching: increased vaso-dilation and/or inflammation brought to the surface
- Decreased Blood Pressure: due to vaso-dilation and/or nervous system sedation

Suggested after care recommendations:

Drink plenty of water, to help eliminate toxins out of the body. Avoid showers, steam, sauna and exercise immediately following cupping bodywork. Light stretching and range of motion exercises are beneficial. Exercise the next day will help increase circulation to aid in fading of cup kisses.

The FasciaBlaster™ is a tool used to release adhesions and restrictions in the Fascia, promote blood flow and increase range of motion. Similary to cupping, because of the increased circulation and breakup of myofascial adhesions, some discoloration in the skin may occur. It is temporary and part of the body's normal healing process.

Contraindications: People who are on blood thinners should not experience Cupping. If you start taking such medication please inform the therapist so your treatment plan can be adjusted. The therapist, Fernanda Santiago, LMBT, CNMT has provided me with information on the Cupping bodywork techniques as well as Facia Blaster techniques. If I choose to experience this therapy in my treatment, I understand the effects and after-care recommendations. It has been explained to me that there is the possibility of a temporary skin discoloration or "cup kiss", appearing as tissue is released. I am aware that a "cup kiss" is NOT a bruise and that it will dissipate within a few hours to a few days. I understand that all treatments by the massage therapist at this facility are therapeutic in nature. I agree to notify the therapist of any physical discomfort experienced during the session. I have stated all relevant physical conditions, and will inform the therapist of any changes in my health.

Print Name: _____ Signature:_____