



**Integrated
Wellness
Systems**

Medical Massage Therapy

(585) 292-6428

Client Information

In order to maximize the effectiveness and safety of your massage session, please take the time to carefully complete this questionnaire. This information will be treated confidentially. Your feedback is appreciated.

Name: _____ DOB: _____ Referred By: _____

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

Occupation: _____ Home #: _____ Cell #: _____ Work #: _____

Email Address: _____

Emergency Contact: _____ Relationship _____ Phone #: _____

Are you pregnant now or attempting to get pregnant? () Y () N Have you had a professional massage before? () Y () N

What are your goals/concerns for today's session? _____

Check any of the following that my apply _____ Stress _____ Pain _____ Stiffness _____ Other _____
Please check any of the following conditions that you have now or had recently

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> allergies | <input type="checkbox"/> headaches | <input type="checkbox"/> sciatica | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> sinusitis | <input type="checkbox"/> fainting spells | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> bursitis | <input type="checkbox"/> neck pain | <input type="checkbox"/> loss of balance | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> cancer | <input type="checkbox"/> chest pain | <input type="checkbox"/> broken bones | <input type="checkbox"/> menstrual pain/PMS |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> blood clots | <input type="checkbox"/> abdominal disorder | <input type="checkbox"/> skin disorders/conditions |
| <input type="checkbox"/> edema | <input type="checkbox"/> heart condition | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> numbness hands/feet |
| <input type="checkbox"/> herniated disc | | | |

Please state any recent injuries, medical treatments or conditions (not listed above) _____

Are you under medical care or supervision at this time? () Y () N If so what for? _____

Are you currently taking any medication? () Y () N If so, please list: _____

Physician Name: _____ Phone #: _____

Do you wear () contacts, () dentures, () hearing aid?
Do you experience any difficulty lying on your () back, () front, () side?

PLEASE READ THE FOLLOWING AND SIGN BELOW

I acknowledge that massage therapy is not a substitute for medical diagnosis and treatment.
I understand that payment in full is expected at the end of my session, unless prior arrangements have been made.
I understand I am responsible for payment of any appointment cancellation or forfeiture of gift certificate with less that 24 hours notice.
I understand that inappropriate actions or language is cause for termination of my session.
We reserve the right to refuse service to anyone for any reason.

I give my consent to receive treatment _____ **Date** _____