Client Information

Today's Date

Name Last First Middle Initial

Date of Birth Month / Day / Year Sex F ☐ M ☐

Email: Referred By:

Phone ( ) - Home ☐ Mobile ☐ Work ☐

Our systems are set to send automatic appointment reminders, please select your prefered method of contact.
Email ☐ Mobile Text ☐ Cell Phone Carrier (needed for text reminders):

Address

City State Zip

Occupation

Emergency Contact Phone ( ) -

Healthcare Provider Phone ( ) -

Current Health

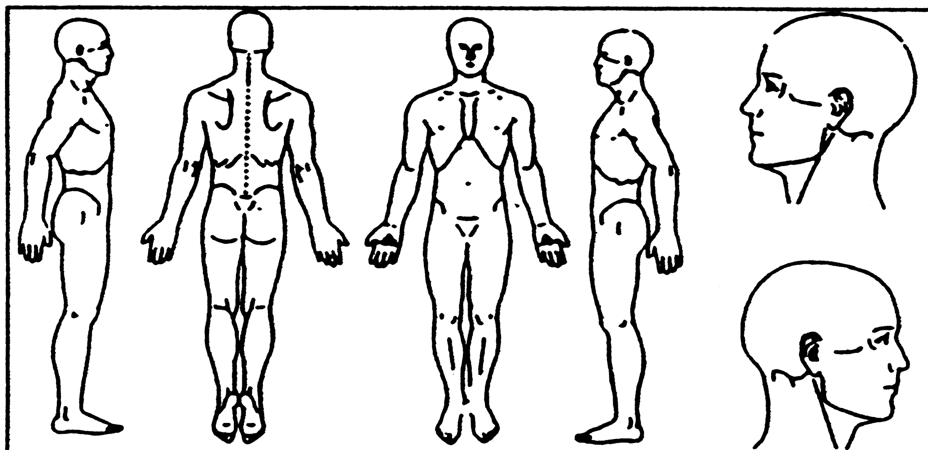
Have you ever received massage therapy before? Yes ☐ No ☐ Frequency

Today's primary concern/goal:

Please circle on the diagram any areas of pain, tenderness, numbness, or stiffness. Please "X" any areas of swelling, bruises, or open wounds.

Please check any of the following that apply to your current health:

☐ Pregnancy	☐ Heart Conditions	☐ Arthritis
☐ Difficulty Breathing	☐ Infections	☐ Blood Clots
☐ Cancer	☐ Circulatory Conditions	☐ Diabetes
☐ Skin Disorders	☐ Allergies	☐ Chronic Pain
☐ Migraines	☐ Sciatica	☐ Carpal Tunnel
☐ High Blood Presure	☐ Joint Replacement	☐ Insomnia
☐ Fatigue	☐ Depression	☐ Skin Allergies



Other:

Current Medications:

Is there anything I should know to ensure your comfort?

Health History

Surgeries:

Accidents:

Major Illnesses:

Other:

Consent for Care

It is my choice to receive massage therapy at Turning Point Wellness, Inc. I am aware of the benefits and risks of massage and give my consent for treatment. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Client's Signature:	Date: