



Client Information

Today's Date _____

Name	Last	First	Middle Initial
Date of Birth	Month / Day / Year		Sex F <input type="checkbox"/> M <input type="checkbox"/>
Email:	Referred By:		
Phone () -	Home <input type="checkbox"/>	Mobile <input type="checkbox"/>	Work <input type="checkbox"/>

Our systems send automatic appointment reminders, please indicate your cell phone carrier for text reminders
Email Mobile Text Cell Phone Carrier : _____

Address _____

City	State	Zip
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Occupation _____

Emergency Contact	Phone () -
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Healthcare Provider	Phone () -
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Current Health

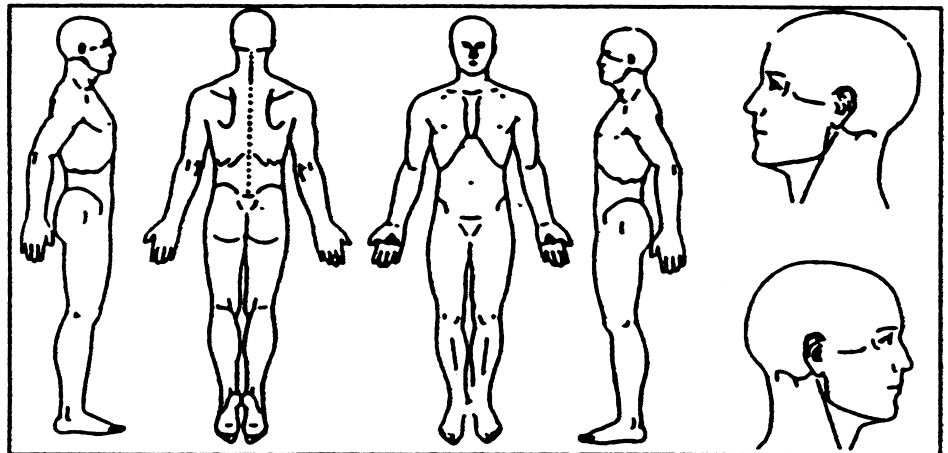
Have you ever received massage therapy before? Yes No Frequency _____

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:

- | | | |
|---|---|---|
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Infections | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Circulatory Conditions | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Skin Disorders | <input type="checkbox"/> Allergies | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Carpal Tunnel |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> 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: _____
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