Confidential Client Record

Name: _____ Date: _____

Street: _____ Town: _____ State: ____ Zip: _____

Phone: _____ (cell? __yes, __no) (text messages accepted? __yes, __no)

Email: _____

Occupation: _____ Birth date: _____

Do you use: Caffeine: _____ Nicotine: _____ Alcohol: _____

Allergies: _____

Primary goals for today's session: **_____**

How did you hear about me?

___Website ___ Newsletter ___ Business Card __ Referral Other: _____

Medical Information

Please check any current conditions (now) or previous conditions (past). Please add comments for clarification.

Now	Past	Condition	Comments
		Recent injury	
		Swelling/inflammation/edema	
		Muscle or joint sprain/strain. If so, muscle relaxants?	
		Muscle or joint pain/stiffness	
		Pinched nerve, sciatica, numbness or tingling	
		Bruise easily	
		Sensitive to touch/pressure	
		High/Low blood pressure	
		Blood clots	
		Cancer diagnosis, surgery, radiation, chemotherapy	
		Stroke, heart attack	
		Bypass surgery/pacemaker	
		Varicose veins	
		Shortness of breath, asthma	
		Neurological (e.g. MS, Parkinson's, chronic pain)	
		Epilepsy, seizures	
		Headaches, Migraines	
		Dizziness, ringing in the ears	
		Digestive conditions (e.g. Crohn's, IBS)	
		Gas, bloating, constipation	

Now	Past	Condition	Comments
		Kidney disease, infection	
		Arthritis (rheumatoid, osteoarthritis)	
		Osteoporosis	
		Degenerative spinal disc disease or disc herniation	
		Scoliosis	
		Broken bones	
		Allergies	
		Diabetes	
		Endocrine/thyroid conditions	
		Skin conditions	
		Depression, anxiety	
		Memory Loss, confusion, easily overwhelmed	
		Pregnant (or trying to become)	

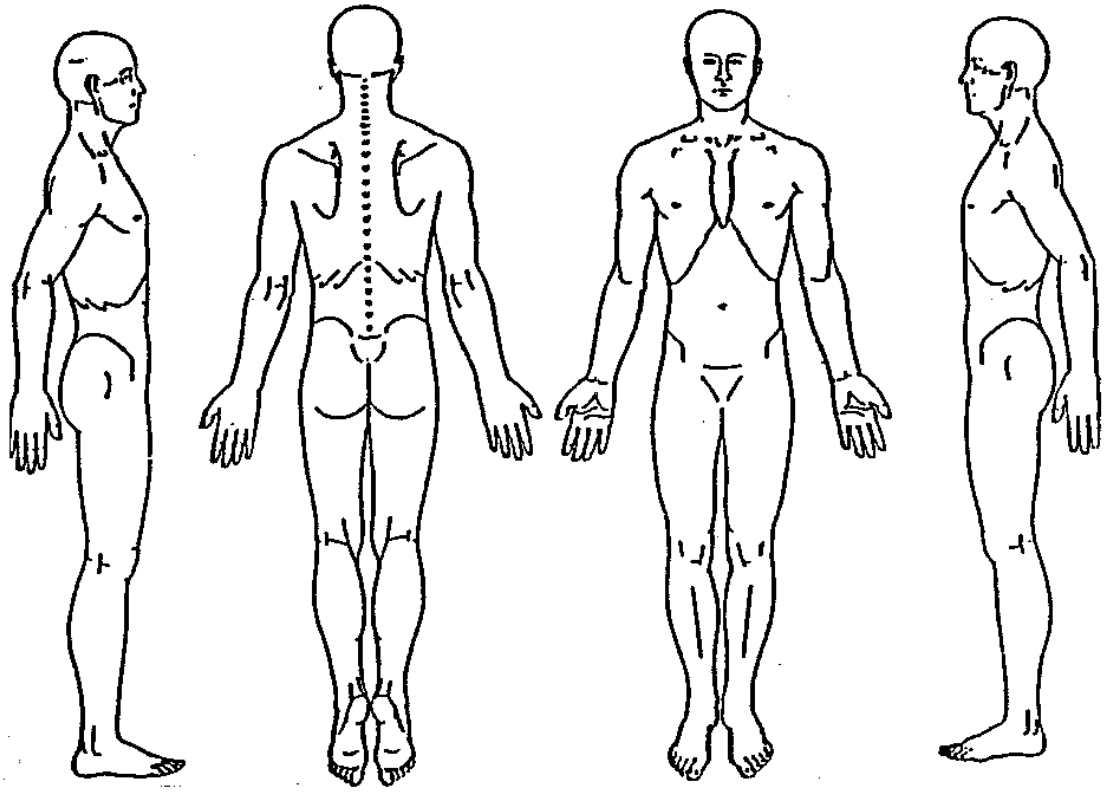
Current medications taken: _____

Primary Care Physician(s): _____

Please use this space to provide any additional medical or health information including any traumas as well as all muscle, bone, or joint injuries, including date(s) of onset if you can recall them:

_____
_____
_____

Please mark the diagram below to indicate which areas are currently sore or painful.



The following sometimes occur during massage and energywork. They are normal responses to relaxation and/or touch and you need not be embarrassed or suppress them. Trust your body to express what it needs to:

- Softening of muscle tissue
- Sighing
- Yawning
- Need to move or change position
- Movement/release of intestinal gas
- Emotional Release
- Energy shifts
- Stomach gurgling
- Memories arising

Please read through the following information and sign below:

Cancellation Policy: 24-hour notice is required for appointment cancellations. This allows for your surrendered appointment to be filled, valuing the time of your practitioner and honoring integrity-based business practice. Appointments cancelled or rescheduled with less than 24 hours notice require immediate payment in full for the scheduled service. Messages concerning cancellations and rescheduling can be left 24/7 at 585-967-0009.

Consent for treatment: If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the techniques may be adjusted to my level of comfort. I further understand that massage/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. I also give my permission to the practitioner to discuss information pertinent to my health condition(s) and treatment with my other health care providers. Understanding all of this, I give my consent to receive care.

Signature: _____ Date: _____

Consent for a minor: By my signature below, I hereby authorize Hallie Sawyers to administer massage/bodywork to my child or dependent.

Signature of Parent or Guardian:

_____Date:_____