Client Information

Name: _____DOB:_____

Address:_____

City/State/Zip:_____

Phone (Day):_____ Phone (Eve): _____

Email:_____

Emergency Contact:_____ Phone:_____

Referred By: _____

Please answer only if receiving bodywork:

Are you here today for pain relief? O Yes O No

Where is the pain located?_____

What is the level of your pain? O Light O Moderate O Severe

Are you experiencing any numbness or tingling? O Yes O No O Sometimes

How long have you had your pain? O 1-7 days O 2-4 weeks O Several months/years

For women ~ Are you pregnant at this time? O Yes O No

Do you have a pacemaker? O Yes O No Other implantable devices? O Yes O No

Are you now under a physician's care? O Yes O No If Yes, please explain:

_____

_____

_____

Are you currently taking any medication/herbs/supplements? O Yes O No If Yes, please list:

_____

_____

_____

Please check any of the following that may apply to you:

☐ Headaches/Migraines	☐ Cancer	☐ Digestive Conditions
☐ Varicose Veins	☐ Stress	☐ Heart Conditions/Stroke
☐ Arthritis	☐ Allergies	☐ Contagious Diseases
☐ Depression	☐ Insomnia	☐ Low Blood Pressure
☐ Constipation	☐ Asthma	☐ High Blood Pressure
☐ Diabetes	☐ Back/Neck Pain	☐ Other_____

I understand that the services offered are not a substitute for medical care and that any information provided by the practitioner is for educational purposes only and is not diagnostic or prescriptive in nature. If I experience any pain or discomfort, I will immediately inform the practitioner. Because some services should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions. I agree to actively participate as much as possible in my own healing.

Client Signature:_____Date:_____

Practitioner Signature: _____ Date:_____

Consent to Treatment of Minor: By my signature below, I hereby authorize for my child or dependent to receive services as they deem necessary.

Parent/Guardian: _____**Date:**_____