

KMA Essential Health Client Information



Name: _____ Phone: _____

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

Referred By: _____ Email Address: _____

To receive appointment reminder

In case of emergency contact: _____ Phone: _____

Date of Birth: ____/____/____ (Senior DISCOUNT {65+ years} and Birthday DISCOUNT)

General and medical information:

Have you ever had a professional massage or bodywork session? Yes No How recently? _____

What are your massage and bodywork goals? _____

What kind of pressure do you prefer? Light Medium Firm

If you answer "yes" to any of the following questions, please explain as clearly as possible.

- | | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you frequently suffer from stress? | <input type="checkbox"/> Yes <input type="checkbox"/> No Any broken bones in the past two years? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No Any injuries in the past two years? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you experience frequent headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have tension or soreness in a specific area? Please specify: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant? Weeks _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from arthritis? | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing contact lenses? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have cardiac or circulatory problems? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing dentures? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from back pain? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have high blood pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have numbness or stabbing pains? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from epilepsy or seizures? | <input type="checkbox"/> Yes <input type="checkbox"/> No Are you sensitive to touch or pressure in any area? Specify _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from joint swelling? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have varicose veins? | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had surgery? Year: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any contagious diseases? | Specify _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have osteoporosis? | <input type="checkbox"/> Yes <input type="checkbox"/> No Other medical conditions or taking any medications I should know about? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any allergies? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have athlete's foot? | Comments _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you bruise easily? | _____ |

CAREFULLY READ THE FOLLOWING INFORMATION, SIGN WHERE INDICATED.

If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated (not advised). A referral from your primary care provider may be required prior to services being provided:

I understand the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscle tension. If I experience any pain or discomfort during the session I will immediately inform the practitioner so the pressure and/or stroke may be adjusted to my level of comfort. I further understand massage/bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and I should see a physician, chiropractor or other qualified medical specialists for any medical or physical ailment of which I am aware. I understand massage therapists/bodyworkers are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness and nothing said in the course of the session(s) given should be construed as such. Because massage/bodywork may be contraindicated, I affirm 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 there shall be no liability on the practitioner's part should I forget to do so.

Client Signature: _____ Date: ____/____/____

Parent/Guardian: _____ Date: ____/____/____