

Crystal Olson: Innergized Movement Massage

Client Name: _____ Date: _____
Date of Birth: _____ Gender: _____
Address: _____
Phone: _____ Email: _____
Referred by: _____
Emergency contact: _____ Phone: _____

Physician/Health-care Provider name: _____ Phone: _____
Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes No
Do you have a physician referral/prescription? Yes No
Are you seeking insurance reimbursement? Yes No If yes, please complete the Billing Information form.
Type of insurance coverage for this claim: Car Collision Worker's Compensation Private Health

Massage Information

Have you ever received professional massage/bodywork before? Yes No
How recently? _____
What types of massage/bodywork do you prefer? _____
What kind of pressure do you prefer? Light Medium Firm
What are your goals/expected outcomes for receiving massage/bodywork?

How do you feel today? _____
List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)?
 Yes No
Explain:

List the medications you currently take:

Are you wearing contacts? Yes No
Are you wearing dentures? Yes No
Are you wearing a hairpiece? Yes No
Are you pregnant? Yes No

Client Name:

Date:

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment?

Circle any of the following health conditions that you currently have (If you are unsure, please ask):

blood clots, infections, congestive heart failure, contagious diseases, pitted edema

Please answer honestly, as massage may not be indicated for the above conditions.

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

Current Past Muscle or joint pain _____

Current Past Muscle or joint stiffness _____

Current Past Numbness or tingling _____

Current Past Swelling _____

Current Past Bruise easily _____

Current Past Sensitive to touch/pressure _____

Current Past High/Low blood pressure _____

Current Past Stroke, heart attack _____

Current Past Varicose veins _____

Current Past Shortness of breath, asthma _____

Current Past Cancer _____

Current Past Neurological (e.g. MS, Parkinson's, chronic pain) _____

Current Past Epilepsy, seizures _____

Current Past Headaches, Migraines _____

Current Past Dizziness, ringing in the ears _____

Current Past Digestive conditions (e.g. Crohn's, IBS) _____

Current Past Gas, bloating, constipation _____

Current Past Kidney disease, infection _____

Current Past Arthritis (rheumatoid, osteoarthritis) _____

Current Past Osteoporosis, degenerative spine/disk _____

Current Past Scoliosis _____

Current Past Broken bones _____

Current Past Allergies _____

Current Past Diabetes _____

Current Past Endocrine/thyroid conditions _____

Current Past Depression, anxiety _____

Current Past Memory Loss, confusion, easily overwhelmed _____

Comments:

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes 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. Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____

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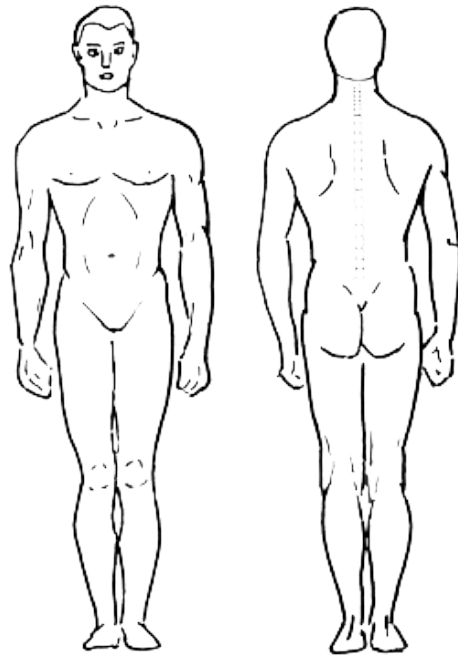
Body Map

Client Name: _____ Date: _____ Date of Birth: _____

Depict how you are feeling today by drawing a circle on the figures representing the size and shape of the following symptoms. Place the letter representing the symptoms in or near the circle:

P = Pain, ache, or tenderness

S = Stiffness in the joint or muscle



Rate how you are feeling today by drawing a circle around the number that best represents how you are doing today:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Able to do everything 0 1 2 3 4 5 6 7 8 9 10 Not able to do anything

Comments:

Is there anything else I should know about how you are feeling today or about your health in general?

Signature: _____ Date: _____