

Health Information

Client Contact Information

Client Name: _____ Date: _____

Date of Birth: _____ Gender: M F

Address: _____

Phone: _____ Email: _____

Emergency Contact: _____ Phone: _____

Physician/Health Provider Name: _____ Phone: _____

Where did you hear about us? Check all that apply:

Groupon Facebook Yelp Other: _____

Massage Information

Have you ever received massage / bodywork before? Yes No

How recently? _____

What types of massage / bodywork do you prefer?

What are your goals / expected outcomes for receiving massage / bodywork?

Please list any needs I should prepare for:

Do you have any of the following symptoms? Describe how they affect your daily living (i.e. sleep, exercise, work, childcare, etc).

Stress _____

Pain _____

Stiffness _____

Numbness/tingling _____

Swelling _____

Other _____

What medications are you currently taking?

Are you currently pregnant? Yes No

Do you have cancer? Yes No

Momentum Therapeutic Massage

Inside Shine Salon, 32241 Crown Valley Pkwy, Dana Point, CA 92629

Health Information

Health History

Have you experienced any of the following? Check all that apply and explain:

- Allergies _____
- Arthritis _____
- Blood clots _____
- Blood pressure conditions _____
- Chronic pain _____
- Diabetes _____
- Fibromyalgia _____
- Headaches _____
- Heat sensitivity _____
- Heart problems _____
- History of Strokes _____
- Infections _____
- Injuries _____
- Insomnia _____
- Immune system deficiencies _____
- Lupus _____
- Skin conditions _____
- Surgeries _____
- Varicose veins _____
- Other _____

Areas of stress or pain: (select all that apply and the pain level associated with it)

- | | | |
|--|---|--|
| <input type="checkbox"/> Neck
0 1 2 3 4 5 6 7 8 9 10
No Pain High Pain | <input type="checkbox"/> Back
0 1 2 3 4 5 6 7 8 9 10
No Pain High Pain | <input type="checkbox"/> Legs
0 1 2 3 4 5 6 7 8 9 10
No Pain High Pain |
| <input type="checkbox"/> Shoulders
0 1 2 3 4 5 6 7 8 9 10
No Pain High Pain | <input type="checkbox"/> Arms
0 1 2 3 4 5 6 7 8 9 10
No Pain High Pain | <input type="checkbox"/> Other _____
0 1 2 3 4 5 6 7 8 9 10
No Pain High Pain |

Circle any areas on which you are uncomfortable having therapeutic massage:

Abdomen Face Feet Scalp Gluteal region Pectoral muscles

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, diagnoses, 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 sexual suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for the payment of the scheduled appointment. Understanding all this, I give my consent to receive care.

I understand that close contact with people increases the risk of infection from COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage from this practitioner. I also understand that my name and contact information might be shared with the state health department in the event that a client or practitioner at this facility tests positive for COVID-19. My contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department.

Client Signature: _____ Date: _____