

RehabExperts Massage Therapy Client Profile
(Please PRINT Clearly)

Name _____ DOB _____ Age _____

Address _____

Phone () _____ Best time to call _____ Email _____

Would you like to receive Client Exclusive Discounts or Appointment Reminders via email? Yes No

Emergency Contact _____ Phone () _____

Please answer the following to the best of your knowledge

How did you learn of REMT? _____

May I send a thank you gift? Yes No Address _____

City _____ State _____ Zip _____

1. Are you currently being treated by a Care Provider, Chiropractor or Acupuncturist? _____

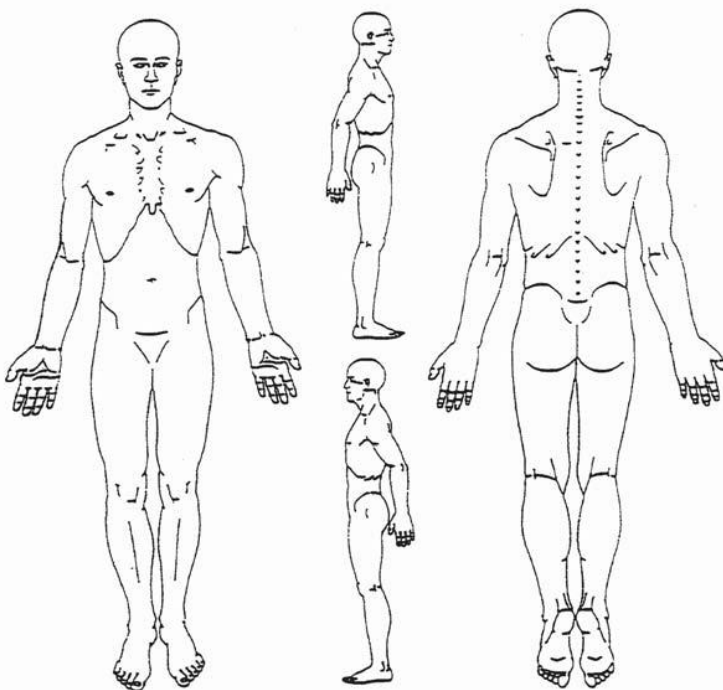
2. Please list any Over the Counter or Prescription Medication(s) you are currently taking (name only) _____

3. Do you perform any repetitive movements during your work, sport, or hobby? _____

4. Do you have any difficulty lying on your stomach, back, or side? _____

5. Do you have a particular goal in mind for today's session? _____

Please circle the specific areas you would like the massage therapist to focus on.



Continue on next page

Client Profile, continued...

Please "X" those that are applicable

- | | | |
|---|---|---|
| <input type="checkbox"/> Arthritis or Gout | <input type="checkbox"/> Breathing Difficulty or Asthma | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Bone or Joint Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Broken Bone within Two Years | | <input type="checkbox"/> Herpes/Shingles |
| <input type="checkbox"/> Bulging or Herniated Disc | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Cold Sores/Warts |
| <input type="checkbox"/> Fused Vertebrae | <input type="checkbox"/> Decreased Sensation | <input type="checkbox"/> Impetigo/Scabies |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Lice/Ring Worm |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Rash/Dermatitis/Hives |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Numbness or Tingling | |
| <input type="checkbox"/> Spinal Ailment | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Cancer or Benign Tumors |
| <input type="checkbox"/> Recent Strain or Sprain | <input type="checkbox"/> Sensitivity to Touch or Pressure | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Surgical Repair/Replacement | <input type="checkbox"/> Sharp Stabbing Pains | <input type="checkbox"/> Athlete's Foot |
| <input type="checkbox"/> Tendonitis or Bursitis | <input type="checkbox"/> Common Cold/Strep Throat | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> TMJ or Jaw Pain | <input type="checkbox"/> Conjunctivitis | <input type="checkbox"/> Drug/Alcohol/Tobacco Use |
| | | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Kidney Ailment | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Colitis | <input type="checkbox"/> Lymphedema |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Recent Accident, Injury or Illness |
| <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Pregnant, _____ months |
| <input type="checkbox"/> Phlebitis or Varicose Veins | <input type="checkbox"/> Ulcers | <input type="checkbox"/> other: |
| <input type="checkbox"/> Thrombus/Embolism/Aneurysm | | |

Please explain any condition you marked. Is there anything else you feel would be useful for the therapist to know when planning a safe and effect session for you? _____

Please read the following information carefully, print below and then sign where indicated.

I, _____, understand that the bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during a 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 body & energy work 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 therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said during the course of the session should be construed as such. Because 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.

Client Signature _____ Date _____

<p>Consent to treatment of a minor: By my signing below, I hereby authorize Pamela A. Murgo, LMT to administer massage, bodywork, or reiki techniques to my child or dependent, as they deem necessary.</p>	
Signature of Parent/Guardian _____	Date _____