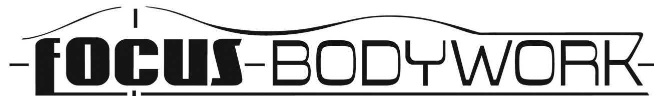


CLIENT INFORMATION FORM

Name:____Birthday:___________ Age:____
Address:__________________________________City:______________State:____Zip:________
Phone:_____________________ e-mail:____
Preferred Contact: *Phone Text E-mail* Referred By:__________________________________
Occupation: _________________________ Activities/Hobbies __________________________

Are you currently receiving care from other health professionals? YES NO
If yes, what type of care (e,g., medical specialty, physical therapy, chiropractor, acupuncture)?
____
____

Have you EVER been diagnosed with any of the following?

- ☐ Migraines/ Headaches
- ☐ Jaw Pain (TMJ)
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Circulation Problems
- ☐ Thrombosis/Embolism
- ☐ Asthma
- ☐ Emphysema/Bronchitis
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Osteoporosis/Osteopenia
- ☐ Rheumatoid Arthritis
- ☐ Osteo-Arthritis: _____________________
- ☐ Cancer (specify type):_________________
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Multiple Sclerosis
- ☐ Auto Immune Disease
- ☐ Fibromyalgia, Chronic Fatigue, and/or IBS
- ☐ Epilepsy
- ☐ Chemical Dependency (i.e. alcohol, drugs)
- ☐ Depression
- ☐ Other:____________________________

Please list any allergies you have:____
If you are pregnant, what is your due date:____________

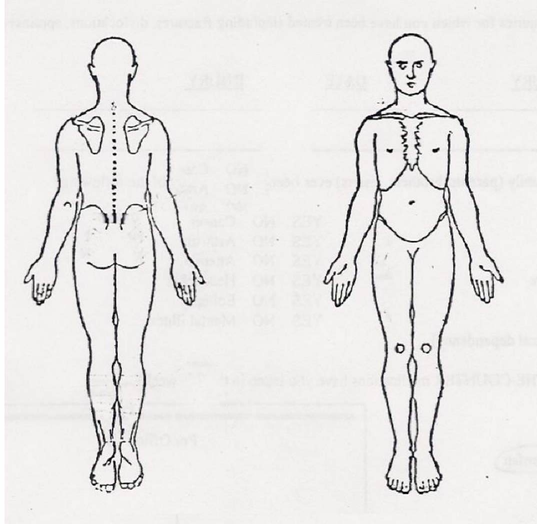
Please describe any significant injuries or accidents and approximate date.
1.____________________________________ 2.___________________________________
3.____________________________________ 4.___________________________________
5.____________________________________ 6.___________________________________

Please list any surgeries or hospitalizations. Include the approximate date and reason.
1.____________________________________ 2.___________________________________
3.____________________________________ 4.___________________________________
5.____________________________________ 6.___________________________________

Please list any prescriptions or over-the counter medications you are currently taking.
____
____

-FOCUS-BODYWORK-

Mark on the diagram where your pain is.



On a scale from 0 to 10 rate your pain when it is at its
Best:________Worst:________
Has your condition been getting BETTER or WORSE

Describe the type of pain you are experiencing:
____

When do you experience the pain:
____

What activities alleviate your pain:
____

What activities aggravate your pain:
____

What is your current exercise/activity routine?
____

Have you had therapeutic massage for this condition? YES NO
If YES, what were the results?
____

What are your goals and expectations from this treatment?
____

I understand that massage therapy given here is for the purpose of relief of muscular tension or spasm, stress reduction, or to increase circulation. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. The massage therapist does not prescribe medical treatment of pharmaceuticals, nor does the therapist perform any spinal manipulations. It has been made clear to me that this massage therapy is not a substitute for medical examination and/or diagnosis and that it is recommended that I see a physician for any physical ailment. Because a massage therapist must be aware of existing physical conditions, **I have stated all my known medical conditions** and take it upon myself to keep the massage therapist updated on my physical health.

Per the Utah Massage Therapy Practice Act (58-47b-501), I consent to massage of and around the breast tissue for the purpose of releasing adhesions and trigger points in the muscle, connective tissue, and scar tissue of the upper torso and/or to increase and improve the flow of lymphatic fluid. When necessary to access affected tissue, if the client consents, the breast tissue may be exposed while that area is being treated. I understand that I can alter, or withdraw, my consent for this treatment and/or treatment plan at any time

Cancellation Policy
In order to allow clients at Focus Bodywork to receive the services we provide, we request a **24-hour notice** of cancellation prior to the time of your appointment. If proper notice is not given, **you will be billed the full amount** of your visit.

Signature____ **Date**______________

[Signature of Guardian, if client is a minor.]