Release PHYSICAL THERAPY

Date:_____/_____/_____

Name:_____ DOB: ____/____/____ Sex: ☐ Female ☐ Male
Last, First, Middle

Email (required): _____

Home Phone:_____ Work Phone:_____Cell phone:_____

Address: _____
Street city state zip code

Occupation:_____ Employer:_____

Emergency Contact:_____ Relationship _____ Phone _____

How did you hear about us? _____

Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use:

_____
_____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along?_____

Any high risk factors?_____

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain_____

What makes it better?

_____
_____

What makes it worse?

_____
_____

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list:

_____
_____

Please indicate any of the following that apply to you.

☐ Cancer	☐ Fibromyalgia
☐ Headaches/Migraines	☐ Stroke
☐ Arthritis	☐ Heart Attack
☐ Diabetes	☐ Kidney Dysfunction
☐ Joint Replacement(s)	☐ Blood Clots
☐ High/Low Blood Pressure	☐ Numbness
☐ Neuropathy	☐ Sprains or Strains

Explain any conditions you have marked above:

_____
_____
_____
_____

Massage Information

Have you had a professional massage before? ☐ yes ☐ no

What type of massage are you seeking?

☐ Relaxation ☐ Therapeutic/Deep Tissue

Other:_____

What pressure do you prefer? ☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain:_____

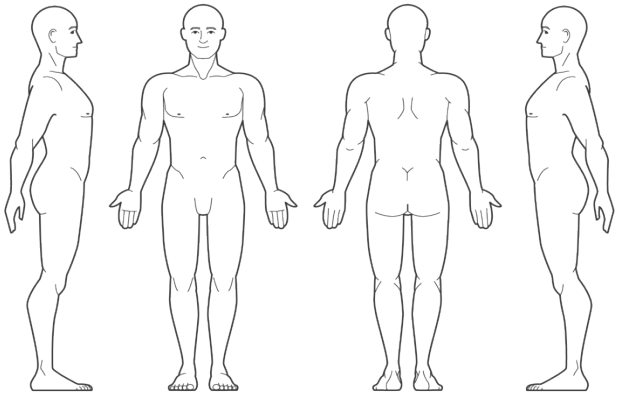
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain:_____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort



By signing below, you agree to the following. I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time. I acknowledge that cancellation charges are $140.00 per missed appointment and that future appointments will not be made until any and all cancellation charges have been paid in full.

_____
Client Signature Date

_____
Therapist Signature Date