|  |  |  |
| --- | --- | --- |
| Client Information | |  |
| Name | | Email |
| Address | |  |
|  | |  |
| Phone | |  |
| Occupation | | Employer |
| Date of Birth | | Referred By |
| Have you had a professional massage or body treatment before? \_\_\_\_Yes \_\_\_\_No | | |
| Primary reason for treatment | | |
| Areas that need attention | |  |
| Have you had an injury or surgery? | | \_\_\_\_Yes \_\_\_\_No |
| If yes, please describe | |  |
|  | |  |
| How would you describe your general health? \_\_\_\_Poor \_\_\_\_Fair \_\_\_\_Good \_\_\_\_Excellent | | |
| How would you describe your lifestyle? | | |
| * Dietary Habits | |
| * Exercise Habits | |
| * Rest/Stress Levels | |
| * Vitamins, Herbs & Medications | |
|  | |
| Do you take in high amounts of any of the following? | | |
| \_\_\_\_Caffeine \_\_\_\_Nicotine \_\_\_\_Alcohol \_\_\_\_Fast Food \_\_\_\_Water | |
| Please check if you have any of the following: | | |
| \_\_\_\_Blood Clots  \_\_\_\_Diabetes  \_\_\_\_Heart Disease  \_\_\_\_Joint Disease  \_\_\_\_Skeletal Injuries  \_\_\_\_Skin Conditions | \_\_\_\_Arthritis  \_\_\_\_Circulatory Disorders  \_\_\_\_High Blood Pressure  \_\_\_\_Low Blood Pressure  \_\_\_\_Hernia/Rupture  \_\_\_\_Varicose/Spider Veins |
| Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Are you pregnant? \_\_\_\_Yes \_\_\_\_No | | |
| Please check any chronic conditions that you may be having: | | |
| \_\_\_\_Abdominal Pain  \_\_\_\_Dizziness  \_\_\_\_Fatigue  \_\_\_\_Sinusitis  \_\_\_\_Joint Pain  \_\_\_\_Constipation | \_\_\_\_Chest Pain  \_\_\_\_Depression  \_\_\_\_Insomnia  \_\_\_\_Migraine Headaches  \_\_\_\_Headache  \_\_\_\_Digestive Problems |
| Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | | |
| Do you have computer implants such as a pacemaker, insulin pump or spinal stimulator? \_\_\_\_Yes \_\_\_\_No | | |
| Is there anything else that we should know prior to your treatment? | | |
|  | | |
|  | | |
| Release Statement | | |
| I understand that all treatments at this facility are therapeutic in nature. I agree to notify the therapist of any physical discomfort or draping issues during the session.  This facility has provided me with information on MediCupping™ therapy. If I choose to experience this therapy in my treatment, I understand the effects and after-care recommendations. It has been explained to me that there is the possibility of a skin discoloration, or “cup kiss”, appearing as tissue is released. I am aware that a “cup kiss” is not a bruise and that it will dissipate within a few hours to a few days.  This facility and the therapist will not be held liable for indications that arise during or after the treatment, and I agree to notify the therapist if there is any discomfort during a session. I have stated all relevant physical conditions and will inform the therapist of any changes in my health. | | |
| Signature: | | Date: |