|  |  |
| --- | --- |
| 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: |