Diligent Medical Massage, LLC Client Intake Form

Client Contact Information

First name *

Enter your first name

Last name *

Enter your last name

Phone Number *

+1 (___) ___-_____

Email *

example@example.com

Birth date *

Select month

Select day

Select year

Street address

Enter street address

City

Enter city

State

Enter state

Zip code

Enter zip code

Emergency Contact Information

Contact Name

Phone Number

Doctor Contact Information (optional)

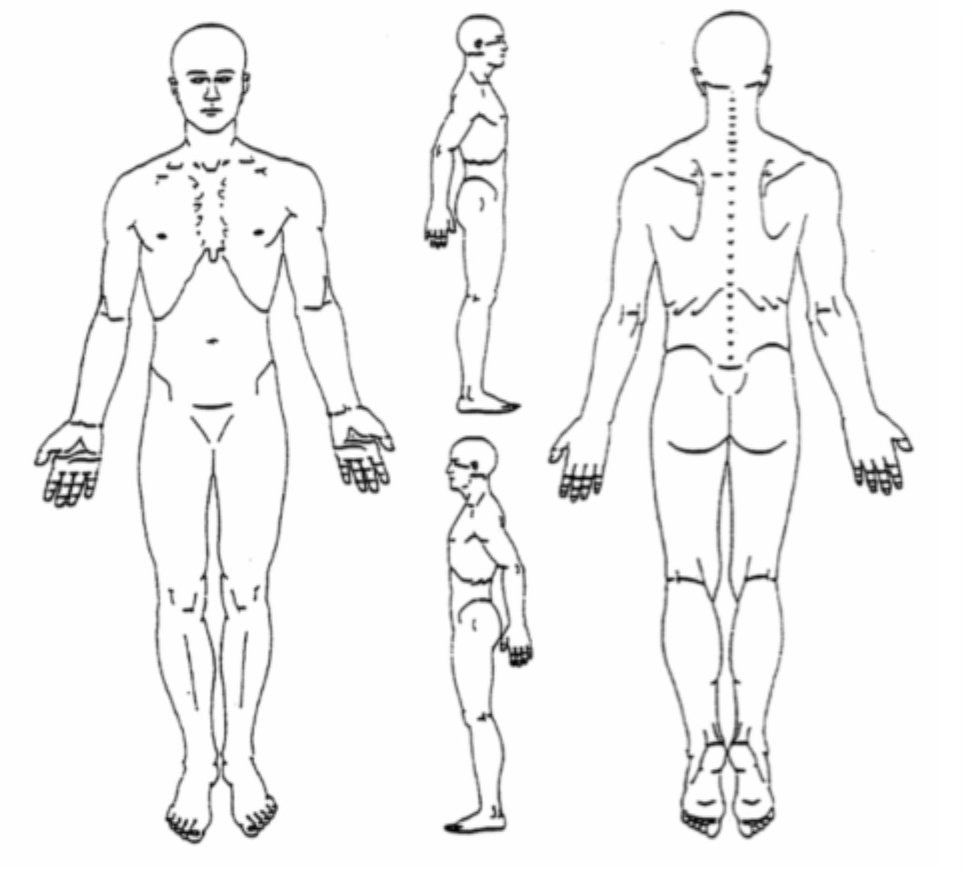
Doctor's Name

Phone Number

How did you hear about us?

Issues to Address

Click or tap the area(s) in question and describe sensation(s) i.e. tight, sharp pain, sore, bruising, dull ache, etc.



Cause of injury or concern

How long since first noticed

What are your treatment goals? (Please Indicate Your Selected Massage Method) *

Past treatments

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COVID-19 SYMPTOMS

Please check the box below if any of the following are true:

- Have had a fever within the last 24 hours
- Recently experienced respiratory/flu symptoms, sore throat, or shortness of breath
- Contact, within the last 14 days, with anyone diagnosed with COVID or related symptoms

- [ ] COVID Symptoms Questionnaire

RESPIRATORY

- [ ] Asthma
- [ ] Shortness of Breath
- [ ] Bronchitis
- [ ] Chronic Cough
- [ ] Emphysema

CARDIOVASCULAR

- [ ] Blood Clots
- [ ] Cold Hands
- [ ] High Blood Pressure
- [ ] Pacemaker
- [ ] Varicose Veins
- [ ] Cardiovascular Accident
- [ ] Congestive Heart Failure
- [ ] Low Blood Pressure
- [ ] Phlebitis
- [ ] Cerebral-vascular Accident
- [ ] Heart Attack
- [ ] Stroke
- [ ] Lymphedema
- [ ] Cold Feet
- [ ] Heart Disease
- [ ] Thrombosis/Embolism
- [ ] Myocardial Infarction

SKIN

- [ ] Bruise Easily
- [ ] Skin Irritations
- [ ] Hypersensitive Reaction
- [ ] Melanoma
- [ ] Skin Conditions

HEAD & NECK

- [ ] Ear Problems
- [ ] Hearing Loss
- [ ] Sinus Problems
- [ ] Vision Problems
- [ ] Vision Loss
- [ ] Migraines
- [ ] Headaches
- [ ] Jaw Pain (TMJD)

INFECTIOUS CONDITIONS

- [ ] Athlete's Foot
- [ ] Respiratory Conditions
- [ ] Hepatitis
- [ ] Skin Conditions
- [ ] HIV
- [ ] Herpes

REPRODUCTIVE

- [ ] Pregnancy
- [ ] Gynecological Issues

FAMILY HISTORY

- [ ] Cardiovascular Conditions
- [ ] Respiratory Conditions

NEUROLOGICAL

- [ ] Burning
- [ ] Numbness
- [ ] Tingling
- [ ] Stabbing Pain
- [ ] Cerebral Palsy
- [ ] Parkinsons
- [ ] Multiple Sclerosis
- [ ] Herniated Disc

MISCELLANEOUS

- [ ] Allergies
- [ ] Cancer
- [ ] Dizziness
- [ ] Hemophilia
- [ ] Mental Illness
- [ ] Surgical Pins or Wire
- [ ] Anaphylaxis
- [ ] Crohn's Disease
- [ ] Epilepsy
- [ ] Arthritis
- [ ] Osteoarthritis
- [ ] Rheumatoid Arthritis
- [ ] Artificial Joints/Special Equipment
- [ ] Diabetes
- [ ] Fibromyalgia
- [ ] Loss of Sensation
- [ ] Osteoporosis
- [ ] Shingles
- [ ] Stress
- [ ] Digestive Conditions
- [ ] Insomnia
- [ ] Gout
- [ ] Lupus
- [ ] Other Diagnosed Diseases
- [ ] Other Medical Conditions

Other Medical Conditions

Allergies and other conditions your provider should be aware of

MEDICATIONS

Please list any medications or drugs you are currently on

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Client Waiver Form

Please take a moment to read and initial the following information:

- I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation, range of motion, and energy flow.
- If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort (sweedish & relaxation massages only). I will not hold my therapist responsible for any pain or discomfort I experience during or after the session. I also understand that your Find & Fix™ technique, and trigger point therapy may cause me to experience extreme discomfort initially that will subside as my provider holds the pressure. I agree to notify the provider if any discomfort becomes unbearable. I agree that my provider has informed me that I may experience soreness that may persist a couple of days, particularly for Find & Fix™ and Trigger Point Therapy, and have been provided with information to help prevent and alleviate this soreness.
- I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.
- I affirm that I have notified my therapist of all known medical conditions and injuries.
- I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.
- I understand that massage is entirely therapeutic and non-sexual in nature.
- By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.

Signature *

Sign above

I have read the statement above and agree to all the policies *

MM-DD-YYYY