Caroline L. Gates, LMT
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T: (856) 521-5219 E: islandfit29@gmail.com

PERSONAL INFORMATION

Name: _____ Date: _____

Street Address: _____ City: _____

Postal Code: _____ Telephone (day): _____ (evening): _____

Email Address: _____

Emergency Contact (Name & Phone#): _____

Weight: _____ Height: _____ Age: _____ Date of Birth: _____ Sex: _____

Occupation: _____ Hours worked per week: _____

Recreational Activities: _____ Frequency: _____

How did you hear about Island Fitness & Massage of SJ?: _____

Reason for seeking this treatment: _____

HEALTH HISTORY

Please indicate the conditions that apply √

_____Headaches (migraine)	_____Headaches (sinus)	_____Headaches (tension)
_____Sinus infections (frequent)	_____Allergies	_____Frequent colds
_____Pregnant currently	_____Shortness of breath	_____Chronic chest congestion
_____Chronic cough	_____Smoker?___(Packs p/day)	_____Night pain
_____Sleep disturbed by pain	_____Rheumatoid Arthritis	_____Osteoarthritis
_____Back pain	_____Neck pain	_____Shoulder pain
_____Chronic constipation	_____Difficult digestion	_____Diabetes
_____Frequent urination	_____Night sweats	_____High blood pressure
_____Low blood pressure	_____Dizziness	_____Diagnosed heart disease
_____Varicose veins	_____Poor circulation	_____Phlebitis
_____Sensitive skin	_____Rashes (frequent)	_____Skin eruptions (frequent)
_____Bruise easily	_____Swollen ankles	_____Contact Lenses
_____Athlete's Foot	_____Depression	_____Pregnant
_____Epilepsy, seizures	_____Endocrine/thyroid conditions	_____Osteoporosis, degenerative spine/disk

List the medications you currently take (including Aspirin, Ibuprofen, Herbs, Vitamins, etc.):

_____

Have you ever received professional massage/bodywork before? Yes ☐ No ☐ How recently? _____

What types of massage/bodywork do you prefer? _____

What kind of pressure do you prefer? Light Medium Firm

What are your goals/expected outcomes for receiving massage/bodywork?_____

How do you feel today? _____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

_____

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No
If Yes, Explain:

_____

Is there anything else I should know about how you are feeling today or about your progress or care to date?

_____

_____

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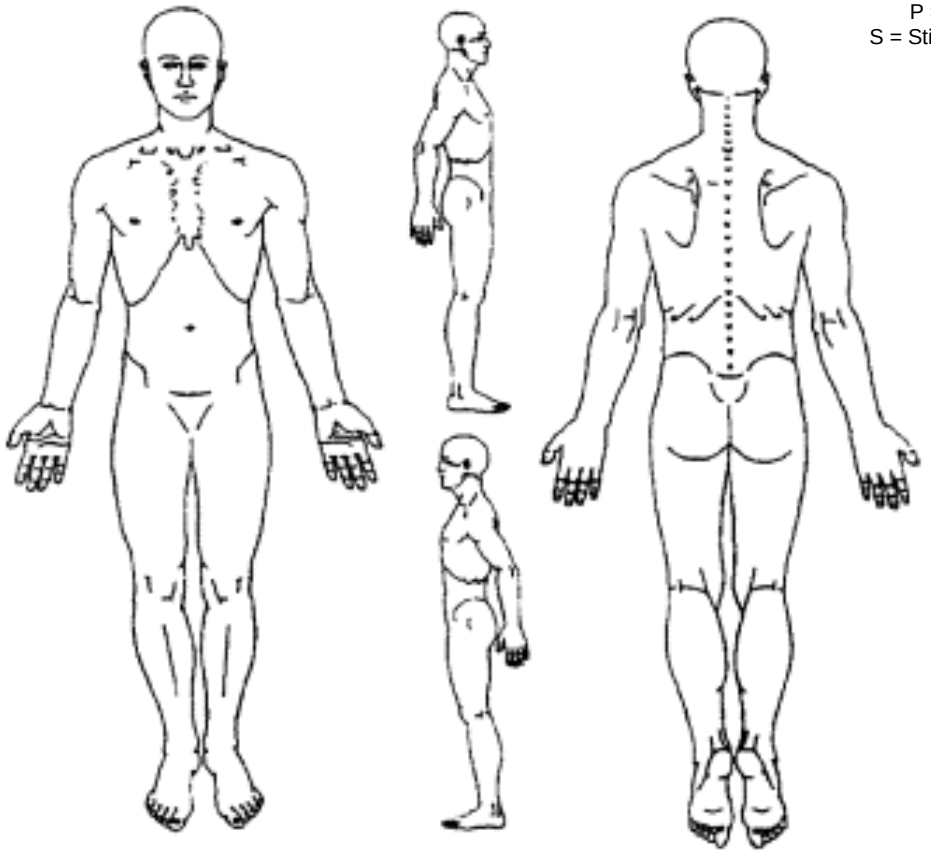
Depict how you are feeling today by drawing a circle on the figures representing the size and shape of the following symptoms. Place the letter representing the symptoms in or near the circle:

P = Pain, ache, or tenderness
S = Stiffness in the joint or muscle



Rate how you are feeling today by drawing a circle around the number that best represents how you are doing today:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Able to do everything 0 1 2 3 4 5 6 7 8 9 10 Not able to do anything

PLEASE READ CAREFULLY AND SIGN BELOW

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

I understand that the nature and purpose of the treatment will be explained to me and that I have the right to stop or modify the treatment at any time, as does my Registered Massage Therapist. I understand I have the right to ask questions at any time. I understand that the benefits of massage therapy include increased circulation to the tissues and increased relaxation, among other effects, and that I may feel temporary soreness post-treatment (24-48 hours) or a slight dizziness on rising from the table. I understand that my therapist must obtain consent to treat areas of my body that I have not previously given verbal consent to have treated. I do consent to treatment; I also understand that verbal consent must be given before any treatment.

I understand that I am responsible for payment in full of all treatment and related fees immediately following each of my appointments by cash, check, Visa or MasterCard. I understand that 24-hours notice by telephone is required to re-schedule any future appointment, or full charges will apply.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____