Dominion Therapeutic & Sports Massage
Confidential Client Information & Consultation Form

Name:_____Date:_____
Last First M.I.

Address:_____
Street Apt. City State Zip

Cell Phone:_____Home Phone:_____

Email:_____
Used for Dominion Therapeutic & Sports Massage Communications ONLY!

Date of Birth:_____Occupation:_____

Emergency Contact:_____Phone:_____

How did you hear about us?_____

Have you had before?_____ How long ago?_____

Where and by Whom?_____

What level of pressure do you prefer? Light_____ Medium_____ Firm_____ Very Firm_____

What is your major area of pain or concern?_____

_____

When did you first notice it?_____What brought it on?_____

What activities agrivate it?_____

Is this condition getting worse? Yes____ No____ Does it interfere with work_____ Sleep_____ Recreation_____

What do you believe is wrong with you?_____

What have you done to get relief?_____

Has there been a medical diagnosis?_____ Medical Condition?_____

Exam?_____ Bloodwork? _____ X-Rays? _____ Other?_____

What was the diagnosis?_____By whom?_____

Other areas of pain or concern?_____

PAST HISTORY:

Have you ever had a similar problem before?_____ When? _____
What caused those
episodes?_____

What relieved them?_____

What was the previous diagnosis?_____ What treatments?_____

Did this help? _____ Have you had massage therapy for these conditions?_____ If so, did it help?_____

Are you presently under a doctor's care? _____ If so, for what condition?_____

Name of Physician:_____

Are you taking any: _____ Medications List them:_____

_____ Laxatives _____ Sedatives _____ Sleeping Pills _____ Insulin _____ Blood Thinners

_____ Pain Pills (Type:_____) _____ Vitamins _____ Herbs

_____ Minerals _____ Birth Control Pills _____ Hormone Replacement _____ Other:_____

Please indicate the following habits with: H - Heavy M – Moderate L – Light N – None

_____Alcohol _____Coffee _____Tea _____Tobacco _____Colas _____Sugared Products

_____Artificial Sweeteners _____ White Flour Products _____ Exercise Cravings:_____

Previous Operations:_____

Previous Broken Bones: _____

Previous accidents or injuries:_____

Circle any ***CURRENT*** conditions. **Underline** any you have had as ***PAST*** problems.

Headaches	Muscle Spasms in Neck	Cold Sweats	Shooting Pains in Head	Grating in Neck
Liver Trouble	Sinus Trouble	Tightness in Shoulder	Gallbladder Trouble	Loss of Smell
Loss of Taste	Neuritis Shoulder/Arms	Indigestion	Tightness in Throat	Intestinal Gas
Cold Hands	Pins / Arms & Hands	Constipation	Inflammation of Throat	Constipation
Thyroid Trouble	Kidney Trouble	Shortness of Breath	Bladder Trouble	Face Flushed
T.B.	Diabetes	Cancer	Twitching of Face	Heart Pain
Loss of Memory	Heart Palpitations	Sleeping Problems	Fatigue	Heart Attack
Depression	High Blood Pressure	Swollen Joints	Head Feels Too Heavy	Arthritis
Dizziness	Low Blood Pressure	Blood Clots/Phlebitis	Herniated/Bulging Discs	Anemia
Fainting	Pins & Needles / Legs	Rheumatic Fever	Pinched Nerves in Back	Swollen Ankles
Loss of Balance	Ringing in Ears	Nervous Stomach	Pains in Feet & Legs	Cold Feet
Hayfever	Light Bothers Eyes	Stomach Trouble	Sciatica	Wear Glasses
Ulcers	Asthma	Allergies	Varicose Veins	Nervousness
Epilepsy	Numbness Hands & Feet	Skin Disorders	Excessive Perspiration	Hernia

Others: _____

Are you currently pregnant? (Please circle) Yes No If yes, how many weeks? _____

Exercise/Sport:_____ How often?_____

Recreation/Hobbies: _____ How Often? _____

Please indicate any areas you DO NOT want massaged:_____

If you have a condition requiring consultation with your doctor, please include their contact information:

Physician Name:_____ Phone: _____

Permission to contact medical professional (initials):_____ Date:_____

In compliance with Title 25, Texas Administrative Code, Chapter 140, clients are required to complete the following release prior to the massage session:

PECTORAL / ADDUCTOR / GLUTEAL MASSAGE: Your therapist will provide massage therapy based on your personal preferences and needs. However, therapist will not massage certain muscle groups unless you provide written approval prior to the session. Please Initial:_____

I hereby give consent for my therapist to implement pectoral, adductor and/or Gluteal massage in my therapy sessions. Please Circle: YES NO

DRAPING: For your privacy and comfort, Dominion Therapeutic & Sports Massage requires therapist to use draping with sheets / blankets at all times during every session. Please Initial:_____

CLIENTS STATEMENTS AND UNDERSTANDINGS:
I am not aware of any medical condition or specific symptoms that may be a contraindication for massage therapy. In cases where one or more medical conditions exist, I understand that a referral from my primary care provider is required prior to service, and that the massage I receive is provided for the purpose of relaxation, relief of muscular tension and/or improved circulation. If I experience any pain or discomfort during my session I will immediately inform the practitioner so the technique may be adjusted to my level of comfort. I further understand that massage 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 if any mental or physical ailments exist. I understand that massage 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 any massage session should be construed as medical advice. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep Dominion Therapeutic & Sports Massage updated regarding any changes in my medical profile and understand that Dominion Therapeutic & Sports Massage shall not be liable should I fail to do so.

I understand that any illicit, sexually suggestive remarks, inappropriate behavior or advances made by me will result in immediate termination of the session and I will be responsible for full payment of the scheduled appointment. Likewise, if for any reason I feel uncomfortable I may cease treatment and will immediately end the session. Dominion Therapeutic & Sports Massage reserves the right to refuse service to any client at any time for any reason at Dominion Therapeutic & Sports Massage's sole discretion.

We request that any cancelations occur at least 24 hours in advance, otherwise we reserve the right to charge full price for the appointment.

I have read, understand and agree to be bound by the information and conditions listed above.

Client Signature:_____ Date: _____

Client Printed Name: _____

Dominion Therapeutic & Sports Massage Signature: _____

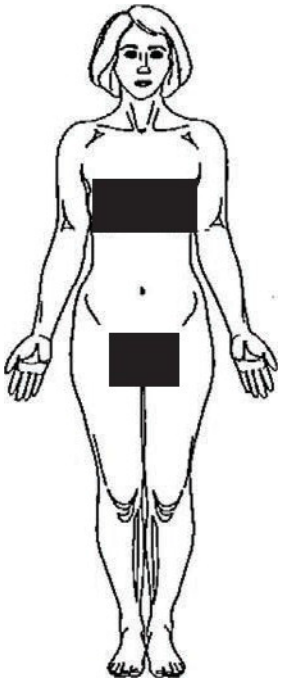
Parent/Guardian Signature:_____ (If Person Receiving Treatment is under 18 Years

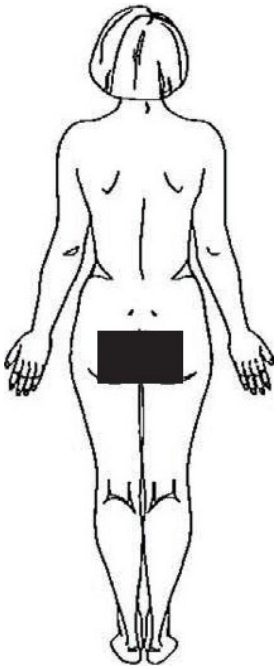
Parent/Guardian Printed Name: _____

Review Treatment Areas

Please mark areas to avoid with an "X", circle that are requests to be treated

Please indicate areas of tension, pain or stress you are currently experiencing on the figures below.





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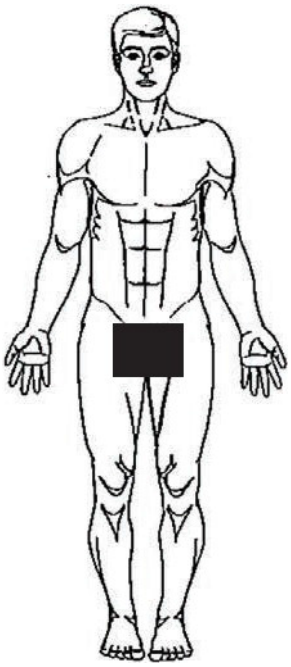

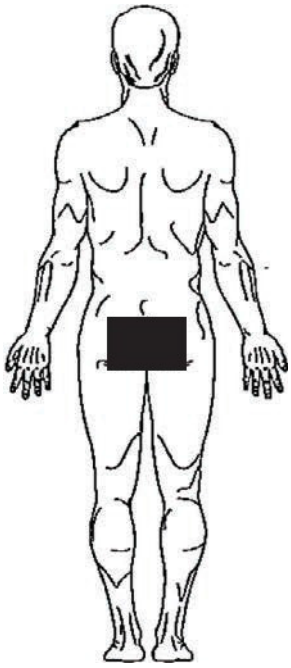

Office Use - Do Not Fill Out Below:

Treatment Type: _____Wellness _____Orthopedic Massgae _____Myofascial Decompression

_____Active Isolated Stretching _____Muscle Activation Techniques (MAT) _____Muscle Energy Therapy

_____Myoskeletal Alignment Therapy _____Fascial Release _____Kinesio(R) Taping