New Client Information

Lake Grove Wellness
MASSAGE AND ACUPUNCTURE

Name: _____ Date of Birth: _____

Address: _____

Contact Phone: ( ) _____ Email: _____

Emergency Contact: _____ Phone: ( ) _____

Were you referred by anyone? _____

Have you ever received massage therapy before? Yes/No Date of last massage: _____

Are you currently seeing a healthcare provider? Yes/No

If yes, please list reason/treatment: _____

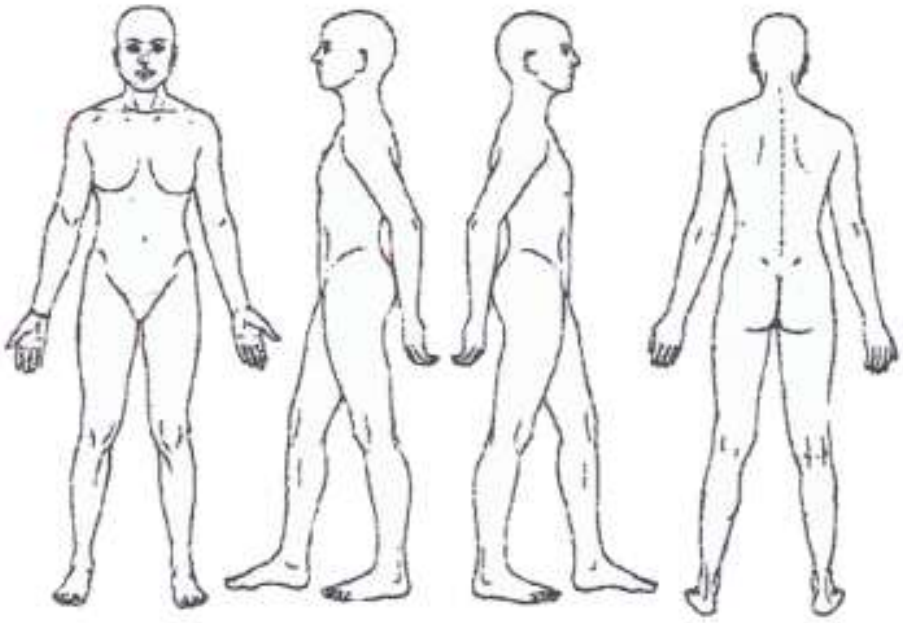
Are you currently taking any medications or supplements (including ibuprofen and aspirin)? Yes/No

If yes, please list name(s) of medication(s) and how often taken: _____

_____

Reason for today's appointment (relaxation, injury, etc.)?_____

Indicate on the pictures below where, if any, are the areas you are feeling discomfort:



Please work these areas today. Check all that apply:

__ Head __ Face __ Neck __ Chest __ Arms
__ Abdomen __ Legs __ Buttocks __ Feet __ Other _____

(continued on back)

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Please check all conditions that have affected your health either recently or in the past:

__arthritis	__panic disorder	__scoliosis	__ broken bones
__diabetes	__ blood clots	__ heart conditions	__ dislocated bones
__ back problems	__ high blood pressure	__ insomnia	__ muscle strain/sprain
__ diverticulitis	__ headaches	__ bruise easily	__ chemical dependency
__ chronic pain	__ cancer	__skin conditions	__ hepatitis (A, B, B other)
__ stroke	__ seizures	__ surgery	__ constipation/diarrhea
__ TMJ disorder	__ whiplash	__ pregnancy	__ auto immune condition

If any of the above are checked, please give details: _____

Do you have any of the following today:

__ skin rash	__ open cuts	__ cold/flu	__ anything contagious
__ injuries/bruises	__ severe pain		

Do you have allergies to:

__ medications	__ food (nuts, etc.)	__ dust, pollen, scents	__ reaction to skin care products

If any of the above are checked, please give details: _____

_____

- I understand that the massage therapy given here is for the purpose of stress reduction, relief from pain, muscular tension or spasm, or for increasing circulation and energy flow.
- I understand that therapists do not diagnose illness or disease.
- I have stated all medical conditions and will update the massage therapist with any changes in my health status.
- I agree to communicate with my practitioner at any time I feel my well-being is being compromised.

I attest that the above is true and accurate to the best of my knowledge.

Signature: _____ Date: _____