Muscles In Motion
Wellness Center

Date:_____

Name: _____ Email: _____
Address: _____
City: _____State: _____ Zip: _____
Home Phone: _____Work Phone: _____ Cell: _____
Occupation: _____ Date of Birth: _____
Preferred Appointment Day and Time: _____
Emergency Contact (Name and Phone Number):
_____
Referred By: Name: _____ Other: _____

What is your major complaint or condition you want to improve?
_____
When did you first notice this condition?
_____
What activities, products, or medications have you used to address this condition?
_____
What aggravates this condition?
_____
What improves this condition?
_____
Are you under medical/therapeutic treatment? ( ) Yes ( ) No
If yes, for what condition?_____
Care Provider/Physician: _____
Phone: _____
May we contact them if necessary ( ) Yes ( ) No
Have you had x-rays taken? ( ) Yes ( ) No If yes, by whom? _____
Please list any medications or supplements you are currently taking:
_____
_____
Specify any known allergies:
_____
_____

Please list any surgeries:
_____
_____

Please list any additional comments regarding your health and well being:
_____
_____

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

MusculoSkeletal
o Headaches
o Joint stiffness/swelling
o Spasms/cramps
o Broken/fractured bones
o Strains/sprains
o Back, hip pain
o Shoulder/neck/arm/hand pain
o Leg, foot pain
o Chest, ribs, abdominal pain
o Problems walking
o Jaw pain/TMJ
o Tendinitis
o Bursitis
o Arthritis
o Osteoporosis
o Scoliosis
o Bone or joint disease

Circulatory and Respiratory
o Dizziness
o Shortness of breath
o Fainting
o Cold feet or hands
o Cold sweats
o Swollen ankles
o Pressure sores
o Varicose veins
o Blood clots
o Stroke
o Heart condition
o Sinus problems
o Asthma
o High/low blood pressure
o Lymphedema

Skin
o Rashes
o Athlete's Foot
o Warts
o Moles
o Acne
o Cosmetic surgery

Digestive System
o Nervous stomach
o Indigestion
o Constipation
o Intestinal gas/bloating
o Diarrhea
o Diverticulitis
o Irritable bowel syndrome
o Crohn's Disease
o Colitis
o Adaptive aids

Nervous System
o Numbness/tingling
o Twitching of face
o Fatigue
o Chronic pain
o Sleep disorders
o Ulcers
o Paralysis
o Herpes/shingles
o Cerebral Palsy
o Epilepsy
o Chronic Fatigue Syndrome
o Multiple Sclerosis
o Muscular Dystrophy
o Parkinson's disease
o Spinal cord injury

Reproductive System
o Pregnancy:
  o Current:- Weeks_____
  o Previous
o PMS
o Menopause
o Pelvic Inflammatory Disease
o Endometriosis
o Hysterectomy
o Fertility concerns
o Prostate problems

Other
o Loss of appetite
o Forgetfulness
o Confusion
o Depression
o Difficulty concentrating
o Drug use_____
o Alcohol use _____
o Nicotine use _____
o Caffeine use _____
o Hearing impaired
o Visually impaired
o Burning upon urination
o Bladder infection
o Eating disorder
o Diabetes
o Fibromyalgia
o Post/Polio Syndrome
o Cancer
o Infectious disease (please list)_____

Informed Consent

I, _____(Client), am seeing Morgan Frisk (Licensed Massage Therapist) for the following services: **Muscle Therapy**.

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

The general benefits of the aforementioned therapies, possible contraindications, and the treatment procedure have been explained to me. I understand that these therapies are not a substitute for medical treatment or medication and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of these therapies.

I have informed the therapist of all my known physical, medical, and psychological conditions and medications, and I will keep the therapist updated on any changes.
If I experience any pain or discomfort during the session, I will immediately communicate that to the therapist so that the treatment can be adjusted.

I understand that all my medical information will not be given out, without my signed consent, from Morgan Frisk and Muscles In Motion Wellness Center is upheld to the HIPAA Laws.

I understand if I am not on time to my appointment, the time will reflect and be shortened.I understand that a **50%** compensation fee will be charged for all cancellations unless notice is given **24 HOURS** prior to scheduled appointment. I also understand if I **"no call/no show"** that a **100%** compensation fee will be charged to me. **Initial here (_____)**

_____	_____	_____
Client Printed Name	Client Signature	Date
_____	_____	_____
Parent or Guardian Printed Name *(If under age 18)	Parent or Guardian Signature	Date