Kulshan Cares, LLC
Mary Ann Percy, M.S., L.M.T.

CONFIDENTIAL CLIENT INFORMATION FORM

NAME: _____DATE:_____

HOME ADDRESS: _____

CITY: _____STATE: _____ZIP:_____

CELL PHONE: _____OK TO LEAVE MESSAGE _____

OK TO TEXT_____

HOME PHONE: _____OK TO LEAVE MESSAGE _____

EMAIL: _____OK TO EMAIL _____

OCCUPATION: _____

DATE OF BIRTH: _____PLACE OF BIRTH: _____

SOCIAL SECURITY #: _____

EMERGENCY CONTACT: _____

PHONE:_____RELATIONSHIP TO YOU_____

REFERRED BY:_____

MASSAGE INFORMATION:

HAVE YOU EVER RECEIVED PROFESSIONAL MASSAGE BEFORE? _____

HOW RECENTLY?_____

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 DAILY ACTIVITIES? _____

IF YES, PLEASE EXPLAIN:_____

ARE YOU WEARING CONTACTS?_____ A HAIRPIECE?_____DENTURES?_____

ARE YOU PREGNANT?_____

HEALTH HISTORY:

Past surgeries of injuries (please indicate type and date):

Do you currently have any of the following health conditions? (if yes, please circle. If unsure, please ask):

Blood clots congestive heart failure contagious disease

Infections pitting edema

Please indicate conditions you now have or had in the past. Please provide detail, including treatment received:

Current past muscle or joint pain_____
Current past muscle or joint stiffness_____
Current past numbness or tingling_____
Current past swelling_____
Current past bruise easily_____
Current past high/low blood pressure_____
Current past stroke or heart attack_____
Current past varicose veins_____
Current past shortness of breath/asthma_____
Current past cancer_____
Current past neurological (eg ms, Parkinson's)_____
Current past epilepsy, seizures_____
Current past headaches/migraines_____
Current past dizziness, ringing in ears_____
Current past digestive conditions (eg ibs, crohn's)_____
Current past gas. Bloating, constipation_____
Current past kidney disease or infection_____
Current past arthritis_____
Current past osteoporosis_____
Current past scoliosis_____
current past fracture/s_____
Current past diabetes_____
Current past endocrine/thyroid conditions_____
Current past depression, anxiety_____
Current past memory loss, confusion_____
Current past allergies_____

COMMENTS:

_____

_____

CONSENT FOR TREATMENT:

IF I EXPERIENCE ANY PAIN OR DISCOMFORT DURING A SESSION, I WILL IMMEDIATELY INFORM THE PRACTITIONER SO THAT THE PRESSURE AND/OR STORKES 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 OR OTHER QULIFIED 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 LIABILTIY 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.

CLIENT
SIGNATURE:_____DATE:_____

PARENT OR GUARDIAN SIGNATURE (FOR MINOR):

_____DATE:_____