RIVERMEDE RETREAT

MYOFASCIAL RELEASE & SPECIAL EVENTS

Confidential Medical History

Name_______________________________________ **Address**____

____________________________ ____

Home ____________________________ **Cell** _____________________________

Email _______________________________________ **Occupation:** __________________________________

Health History

Primary health concerns/goals:

____

Are you currently under the care of a medical Doctor or licensed health care professional **for any above concerns**?

If yes, physicians name and contact #: ____

How long/ when did the concerns become an issue

____ **Secondary Health Concerns:**

____

Are you currently taking *any* **pain medications or blood thinners**?

(If so, please list)

____

Do you have **allergic reactions** to any substances? (**Allergies include peanuts, almonds or oils**) If yes, please list

____

History of trauma (physical or emotional), accidents and/or surgery:

____

____

Therapeutic Goals:

____

Please circle any of the conditions you have ever experienced:

Cardiovascular Disease ~ Numbness/tingling ~ Kidney Disease ~ Diabetes ~ Neck or back pain Varicose Veins ~ Anxiety/Depression ~ HIV/AIDS ~ Menstrual Issues ~ Digestive Problems ~ Sinus Problems ~ Migraine or headaches ~ Chronic Fatigue Syndrome ~ Blood clots Constipation/Irritable Bowel ~ TMJ Dysfunction/Jaw Pain ~ Muscle/Joint Pain Arthritis

I understand that Myofascial Release/Massage Therapy may be contraindicated. A referral from a primary care physician may be required. I further understand that bodywork should not be a substitute for medical examination, diagnosis or treatment, and I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailments that are beyond the scope of practice for my massage therapist. I understand the therapist neither diagnoses illness, disease or medical disorders, nor performs spinal manipulations. I am responsible for consulting a qualified physician for any ailment that I have. I understand that failure to disclose medical conditions, for which MFR or massage is contraindicated, could result in injury or exacerbation of symptoms for which the therapist will not be held legally responsible. I understand that I will be charged full price for appointments cancelled without a 24-hour notice. I will update my therapist with any changes to my medical history. It is my understanding 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 the full payment of the scheduled appointment. By signing below, I agree to the above statements.

Client's Signature: ______________________________________Date: ________________________

Client’s printed name _____________________________________