PAYSON PAIN PREVENTION

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Confidential Client Information Form

The information provided is voluntary on your part. It is not intended for disclosure and will be treated as confidential.

PERSONAL INFORMATION & HISTORY

Name _____ Date _____ Phone _____

Address _____ Email _____

Occupation _____ Emergency Contact _____ Date of Birth _____

Which providers have you seen in the past?

- ☐ Physician
- ☐ Chiropractor
- ☐ Physical Therapist
- ☐ Personal Trainer
- ☐ Acupuncturist
- ☐ Other _____

What Have You Tried to Treat the Pain?

MEDICATIONS?	DID IT HELP?	SIDE EFFECTS?
☐ _____	☐ Yes ☐ No	☐ Yes ☐ No _____
☐ _____	☐ Yes ☐ No	☐ Yes ☐ No _____

OTHER TREATMENTS?	DID IT HELP?
☐ _____	☐ Yes ☐ No
☐ _____	☐ Yes ☐ No

Please Check All That Apply To You—Health History

- ☐ Peptic Ulcer Disease
- ☐ Edema /Legs Swelling
- ☐ Heart Attack
- ☐ Arthritis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Headaches/Migraines
- ☐ Diabities
- ☐ Joint Replacement
- ☐ Blood Clots
- ☐ Numbness
- ☐ Sprains/Strains
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Cancer

Explain Condition or Concern You Have:

_____

_____

_____

_____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?

- ☐ Headaches
- ☐ Numbness
- ☐ Broken Bone <2 years
- ☐ Injuries < 1 year
- ☐ Blood Sugar Issues
- ☐ Fatique
- ☐ Pregnancy
- ☐ High Blood Pressure
- ☐ Mobility Issues
- ☐ Digestive Issues
- ☐ Bruise Easily
- ☐ Sensitiviey
- ☐ Vericose Veins
- ☐ Other _____

Do You Have PAIN NOW? Please Check All That Apply

- ☐ Neck
- ☐ Head
- ☐ Face
- ☐ Arm
- ☐ Hand
- ☐ Knee
- ☐ Feet
- ☐ Ankle
- ☐ Upper Back
- ☐ Upper Leg
- ☐ Front of Body
- ☐ Lower Back
- ☐ Lower Leg
- ☐ Back of Body
- ☐ Full Body

TELL US ABOUT YOUR HEALTH GOALS

What Are Your GOALS For This Session?

SHORT TERM _____

_____

LONG TERM _____

_____

_____

GENERAL LIABILITY RELEASE FORM

By signing below, you agree to the following:

1. I give my permission to receive massage therapy.
2. I understand that therapeutic massage is not a substitute for traditional medical treatment or medications.
3. I understand that the massage therapist does not diagnose illnessess or injuries or prescribe medications.
4. I have clearance from my physician to receive massage therepy.
5. I understand the risks associated with massge therapy include, but are not limited to:
    - Superficial bruising
    - Short-term muscle soreness
    - Exacerbation of undiscovered injury

I therefore release Payson Pain Prevention and the individual therapist from all liability concerning these injuries that may occur during the massage session.

6. I understand the importance of informing my massage therapist of all medical conditions and medications I am taking, and to let the massage therapist know about any changes to these. I understand that there may be additional risks based on my physical condition.
7. I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so he/she may adjust accordingly.
8. I understand that I or the massage therapist my terminate the session at any time.
9. I have been given a chance to ask questions about the massage therapy session and my question have been answered.

Signature _____ Date _____