DATE: _____ Client Name: _____ Referred by: _____

May we add you to our mailing list? ____ no _____ yes Email address: _____@_____

Which method of contact do you prefer : Cell ___ (call or text? _____) home ____ email _____

| Last Name | First | Hm Tel. | Wk. Tel | Cell Tel. |
|---|---|---|---|---|
| Address | | City State | Zip | Spouse Name |
| Occupation | Hobbies, Activities, Sports (for assessing muscles and structure) | | | Birthday |

Have you received therapeutic massage before? Yes _____ No_____ In the previous month? Yes _____ No_____

Are you **pregnant _____** (# of months _____) or **currently nursing a child?** Yes _____ No_____

Check therapies you have received: **Reflexology _____ Reiki _____ Polarity/Cranial Sacral/Acupuncture _____**
**Aromatherapy _____ Alexander or Feldenkrais _____ Chiropractic _____ Other: _____**

**PRIMARY CONCERNS AND/OR INTENT FOR TODAY?** *When did this concern start? What is the cause?* _____
_____.
Have you: Been in a car accident? No ____ Yes ___ If yes when _____ Did you sustain injuries, if so, please describe: _____
_____
Had surgery within the past two years? No ____ Yes ___ If yes when _____, for _____
_____.
Broken bone(s) within the past two years? No ____ Yes ___ If yes when _____, what bones were broken _____
_____.
Sensitivity to pressure or touch in the feet or elsewhere in the body? _____
Allergic reactions to known lotions or oils? _____
_____.

**Are you currently being treated by a** physician, chiropractor or other health professional? For what condition? Please explain:
_____
_____.
Physician:_____ Contact Info.:_____
Medications (prescription or OTC): _____
_____.

**Please Circle All That Apply:**

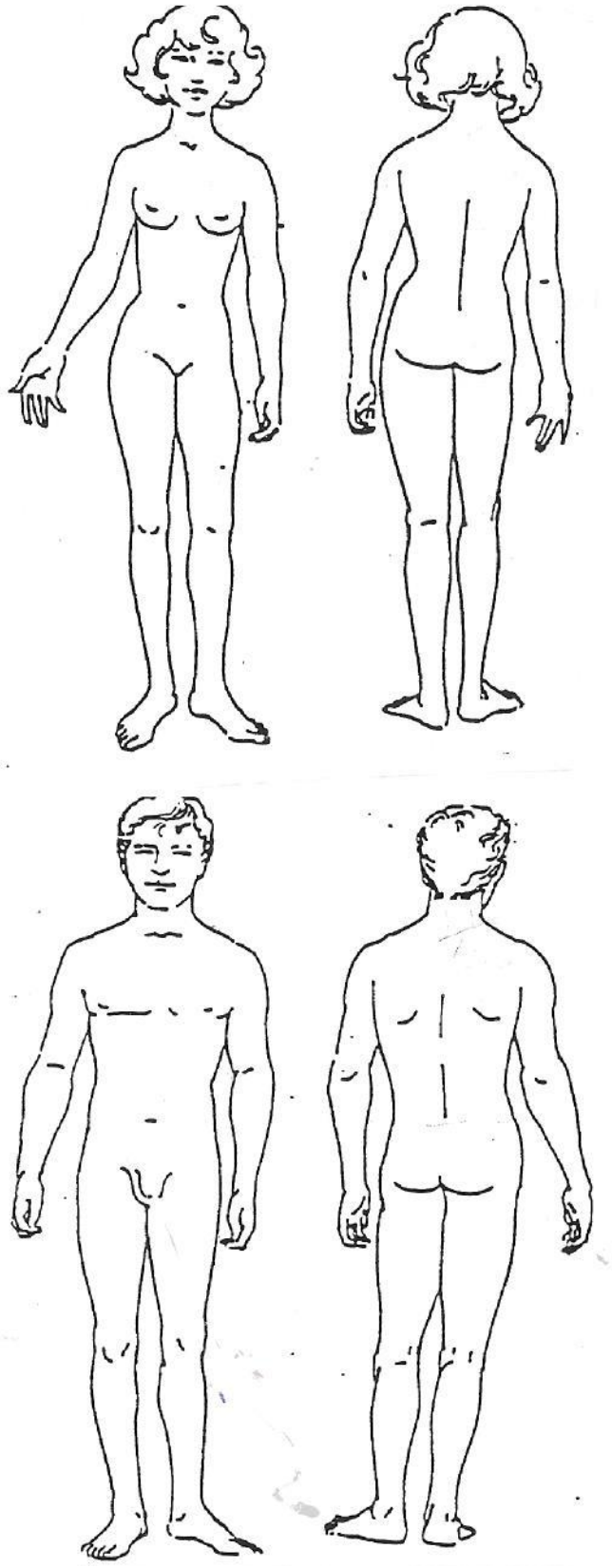
| | | | | |
|---|---|---|---|---|
| *Conditions of the Spine* | *Diabetes (Type 1/Type 2)* | *Insomnia* | *Fatigue* | *Heart Condition* |
| *Arthritis* | *Carpal Tunnel Syndrome* | *Headaches* | *Stress* | *Pacemaker* |
| *Gout* | *TMJ Dysfunction* | *Sinusitis* | *Constipation* | *Defibrillator* |
| *Gout* | *Kidney Dysfunction* | *High Blood Pressure* | *Diarrhea* | *Circulatory Condition* |
| *Varicose Veins* | *Rheumatoid Arthritis* | *Cancer* | *Cold Feet* | *Allergies (pollen, food)* |

*Thyroid Disease:(Hashimoto's, Graves, hyperthyroidism, hypothyroidism)*

***Circle how you rate your*** *(1)* ***Diet:*** *good/fair/poor* *(2)* ***Exercise:*** *good/fair poor* *(3)* ***Stress:*** *high/medium/low*
*Supplements:* _____

## PRIMARY AREAS OF DISCOMFORT AND TENSION

Please mark on the body: **Pain/tenderness X** **Stiff/tight/tense ^^^^^^** **Surgery areas** Circle



Office Use

**Visit # 1** **Date:** _____

X – Pain Reported NOW: (1-5) ……. AFTER (1-5)

Area: _____ Now ____ After _____

Area: _____ Now ____ After _____

Area: _____ Now ____ After _____

^^^ - Tension

_____

_____

O – Surgeries _____

_____

**Visit #2** **Date:** _____

X – Pain Reported NOW: (1-5) ……. AFTER (1-5)

Area: _____ Now ____ After _____

Area: _____ Now ____ After _____

Area: _____ Now ____ After _____

^^^ - Tension _____

_____

O – Surgeries _____

_____

**Visit # 3** **Date:** _____

X – Pain Reported NOW: (1-5) ……. AFTER (1-5)

Area: _____ Now ____ After _____

Area: _____ Now ____ After _____

Area: _____ Now ____ After _____

^^^ - Tension _____

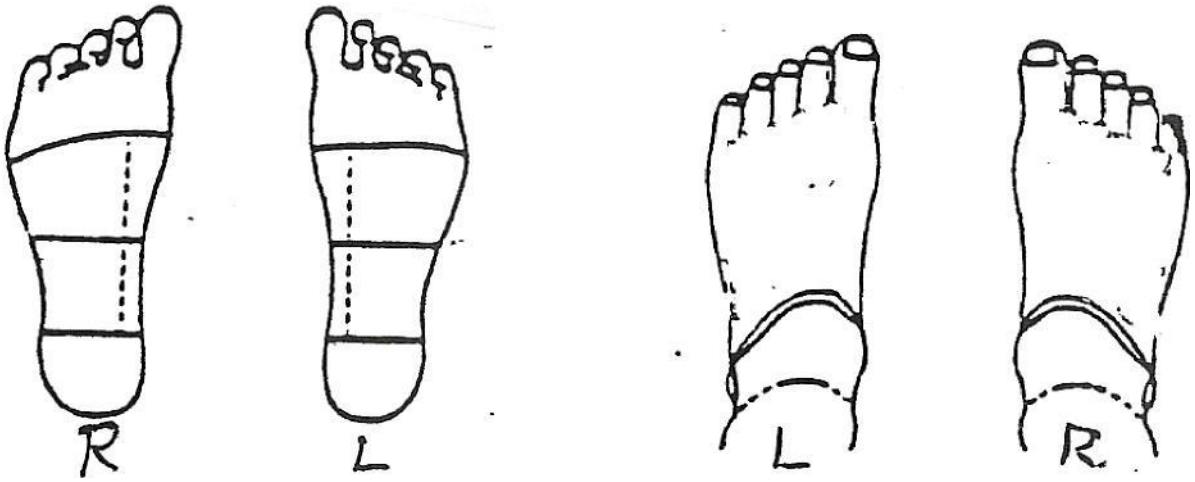
_____

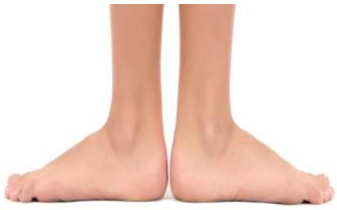
O – Surgeries _____

*Alchemy Massage & Bodywork, SA – 2416 Jackson Keller, San Antonio, Texas 78230 – (520) 370-6461*
*Tyshaun Layne LMT #122473/MTI #3428*

**Please mark all drawings with any of the following (S.P.I.N.T.):**

**(S)** Surgery (P) Painful **(I)** Injury (N) Numbness **(T)** Tingling



OFFICE USE: Right Foot

Left Foot

R-Pain Now (1 -5worst)_____After _____

L-Pain Now (1 -5worst)_____After _____

*Please read the following information and sign below:*

I agree to inform my therapist of my **desired comfort level** for pressure: *light, firm or deep tissue.* I understand any service received in this office is *not a substitute for medical treatment rather it is for wellness-care and self-education*. I agree to update my therapist on my health profile as changes occur. I release Tyshaun R. Layne from all liability for my medical needs at this time or in the future.

CANCELLATION POLICY: Please give 24 hour notice or be subject to a charge for the appointment. Thank you.

*Client Signature* _____ *Date* _____

*Therapist Signature* _____ *Date* _____

*Guardian Signature* _____ *Date* _____

Emergency Contact Information

Name: _____ Relationship: _____

Phone: Cell: _____ Work: _____ Home: _____