CONFIDENTIAL CLIENT INFORMATION

Long Island Myofascial Release

www.LIMyofascialRelease.com 75 Plandome Rd. Manhasset, NY 11030 www.LongIslandMFR.com
516·625-3330
LIMyofascialRelease@gmail.com

First Name _____**M.I.**___**Last Name**_____**Circle:** M / F **Date of Birth** _____

Address _____ _____City_____State ___Zip _____

Please circle your PRIMARY contact number

Home_____Work_____Cell_____ __ __ __ __

EMAIL ADDRESS (confirmations, newsletter, coupons) _____ __ _

***We respect your privacy & will not share your info or bombard you with emails-our newsletter & coupons are sent 1-2X/ month**

How would you like us to CONFIRM your APPOINTMENTS? (PLEASE CIRCLE) EMAIL or TEXT Message

Emergency Contact Name _____Tel#_____

How did you hear about our office? (Friend, Family, Yelp, Goggle, etc.) _____
**(If referred by doctor/specialist please list their name and telephone*

What is your occupation? _____

Is this your first professional massage? **YES, NO** How often do you receive massage? _____

On a scale of 1- 10 *(light ... 10 very deep)* what type of massage pressure do you prefer? _____

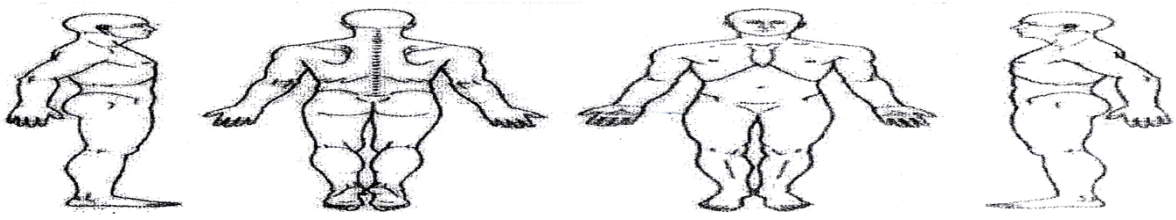
Describe Problems: _____

_____

How long have you had this discomfort / problem(s)? _____

What other treatments have you received for the problem/areas noted? _____

*Please *Circle* any of the following areas of focus you would like the therapist to *focus* on today:



CURRENT HEALTH INFORMATION: Are you currently under the care of a physician? _____ If Yes,

Physician name _____ Please list reason(s) _____

Please list any medications *including pain relievers, vitamins, and/or herbal remedies* taken now or at regular intervals:

_____

_____

C) HEALTH HISTORY *(List and explain the following, PLEASE INCLUDE DATES and treatment you received)*

List Accidents / Injuries / Surgeries / Hospitalizations: _____

_____

_____

See Reverse Side

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Exercise: Times/day week: _____

Activities: _____

History: Please check items that apply

Musculoskeletal	***Digestive***	***Nervous System***
o Osteoporosis / Osteopenia	o Ulcers	o Dizziness
o Arthritis	o Colitis	o ALS
o Hypo / Hyper Thyroidism	o IBS	o Multiple Sclerosis
o Fibromyalgia	o Crone's Disease	o Parkinson's disease
o Chronic Fatigue	o Gluten Intolerance	o Bell's Palsy
o Myofascial Pain syndrome	o Constipation	o Neuritis
o Gout in_____	o Diarrhea	o Spinal cord Injury
o Bursitis	o Gallstones	o Trigeminal Neuralgia
o Tendonitis	o Gas/Bloating	o Seizures
o Plantar Fasciitis	o Chronic Indigestion	***Other***
o Sprain / Strain	o GERD	o Diabetes
o Cysts / Lipomas	*Circulatory*	o Pregnancy
o TMJ	o Heart Problems: _____	o Cancer
o Chronic Headaches	_____	o Kidney disease
o Whiplash	o Stroke	o Hepatitis
o Chromic Pain in:	o Palpitations	o HIV / AIDS
o Neck	o Mitral Valve Prolapse	o Lupus
o Upper-Back	o Anemia	o Postoperative: _____
o Mid-Back	o Hemophilia	o Cystitis
o Low-Back	o Hypertension	o High Stress
o Hip	o Low Blood Pressure	o Grieving
o Knee	o Peripheral Artery Disease	o Anxiety/Panic Attacks
o Foot	o Raynaud's Disease	o Bipolar syndrome
o Leg	o Varicose Veins	o PMS/Menopause difficulties
o Shoulder	o Blood Clots / Phlebitis	o Poor sleep/Insomnia
o Arm	***Skin***	o Allergies affecting
o Wrist/Hand	o Fungal Infections	o Facial skin
o Computer more than 2hrs/day	o Athlete's Foot	o Body skin
Respiratory	o Impetigo	o Nose/Sinuses
o Pneumonia	o Eczema/Dermatitis	o Eyes
o Asthma	o Psoriasis	o Stomach/Gut
o Breathing Problems	o Easily Irritated Skin	o Orthopedic pins or plates
o Sinusitis		
o Other:	o Other:	o Other:
o	o	o

In Order to Cancel OR Reschedule A Session, You Must Call the Office by the Evening Prior to Your Appointment. *If You Do Not Call by The Evening Prior, You Will Be Charged for the FULL Amount of the Service (s}. Therapist's Time That Was Reserved for You *Even If Your Appointment Was Scheduled on the Same Day.*

Appointments Booked Then Missed, Cancelled or Rescheduled on The SAME DAY Will Result in Full Charges for The Services Held.

The above information is accurate. I understand that Massage Therapists do not diagnose disease or prescribe drugs and that they are not a substitute for medical care. I agree to alert my practitioner of any physical/emotional changes as they occur.

Signature_____ Date_____