METTA Wellness Center

WWW.METTAWELLNESSCENTER.NET

CONFIDENTIAL CLIENT INFORMATION & HEALTH HISTORY

Name: _____ Age____ D.O.B. ___/___/____ Height: _____ Weight: _____

☐ ID verified Preferred Name: _____

Address: _____ City: _____ St: ____ Zip: _____

Phone: _____ (Work) _____ Marital Status: _____ Anniversary: _____

Email: _____ How Did You Hear About Me: _____

Occupation: _____ Employer: _____

In Case of Emergency: _____ Phone: (_____) _____

Have you ever experienced a professional massage? ☐ No ☐ Yes (Last massage date?_____)

What types of massage/bodywork have you experienced? _____

What do you hope to accomplish from today's massage? _____

PAIN HISTORY:

Describe any pain/tension/reduced range of motion, etc & how long you've had it? _____

_____

Was there an event or illness that seemed to start it? _____

_____

Are there particular movements associated with your pain? _____

Is the pain worse in the morning or evening? _____

Does anything seem to change your pain? _____ makes it better

_____ makes it worse

Please list accidents, broken bones, injections, injuries, surgeries, etc. (include dates - Most recent listed first)

_____

_____

_____

_____

_____

_____

_____

Are you currently under the care of a physician? ☐ Yes ☐ No

List any medications or vitamins, minerals, supplements you take: _____

_____

EXERCISE:

How much water do you drink per day? _____ Are you able to exercise? ☐ Yes ☐ No

What types of exercise do you do and how frequently? *Include sports, hobbies, and other physical activities*

_____

What type of exercise do you think you would enjoy doing?_____

SELF-CARE:

Stretch regularly? ☐ No ☐ Yes **Use a foam roller?** ☐ No ☐ Yes **Use a massage gun?** ☐ No ☐ Yes

Use balls (tennis ball, lacrosse ball, myofascial release ball) **to work tight muscles or knots?** ☐ No ☐ Yes

Use heating pad? ☐ No ☐ Yes (___ Moist or ___Dry) **Use Ice?** ☐ No ☐ Yes

Use Epsom Salt Baths? ☐ No ☐ Yes

FACE/HEAD:

Do you clench your teeth? ☐ Yes ☐ No Do you grind your teeth? ☐ Yes ☐ No

Do you wear a night guard? ☐ Yes ☐ No Do you have TMJ? ☐ Yes ☐ No

Date of last dental appointment? _____

Date of last eye doctor appointment? _____ Do you wear bifocals or progressive lenses? _____

Do you have any visual disturbances? If yes, please explain: _____

SLEEP:

How many hours of sleep do you typically get per night?_____ Use a CPAP Machine? ☐ No ☐ Yes

Do you experience? ☐ Difficulty falling asleep ☐ Waking Often ☐ Waking Unrefreshed

What position do you sleep in? ☐ Side ☐ Back ☐ Stomach ☐ Half-Stomach/Half-Side ☐ Fetal Position
☐ Arms Overhead ☐ With Pets

Do you put pillows or support ☐ under your knees? ☐ between your legs? ☐ at your chest?

STRESS:

Are you immobile for long periods of time? ☐ At Home ☐ At Work (_____ hrs per day)

Do you perform repetitive movements at home/work? If yes, please describe: _____

_____

Are you able to work? _____ How do you feel after a day of work? _____

If your pain affects your work, please describe how: _____

Rate the level of stress in your life: ☐ High ☐ Medium-High ☐ Medium ☐ Medium-Low ☐ Low

What are your goals regarding your overall quality of life?_____

Given the opportunity, what would you like to do instead of your current work? _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU (in the past or currently):

- ☐ Acupuncture
- ☐ *Alcohol Use*
- ☐ Allergies
- ☐ Alternative Medicine
- ☐ *Anxiety*
- ☐ *Asthma*
- ☐ Back Problems
- ☐ *Blood Pressure High Low*
- ☐ Broken Bones
- ☐ *Bruises Easily*
- ☐ Cancer
- ☐ *Cardiac Problems*
- ☐ Chiropractor
- ☐ *Circulatory Problems*
- ☐ Constipation
- ☐ *Contact Lenses*
- ☐ Contagious Disease
- ☐ *Cosmetic Surgery*
- ☐ CPAP Machine
- ☐ *Dentures*
- ☐ Diabetes
- ☐ *Dizziness/Vertigo*
- ☐ Emphysema
- ☐ Digestive Problems
- ☐ *Disc Problems*
- ☐ Drug Use
- ☐ *Epilepsy or Seizures*
- ☐ Fibromyalgia
- ☐ *(Salt) Float Pod*
- ☐ Foam Roller
- ☐ *Food/Topical/ Smell Sensitivities*
- ☐ Headaches/ Migraines
- ☐ *Hearing Aids/Loss*
- ☐ Herniated/ Bulging Discs
- ☐ Hepatitis
- ☐ *Herpes/Cold Sores*
- ☐ *Hypnosis*
- ☐ Infrared Sauna/Lights
- ☐ *Joint Problems or Swelling*
- ☐ Lupus
- ☐ *Lymphedema*
- ☐ Major Illness
- ☐ *Meditation*
- ☐ Multiple Sclerosis
- ☐ Neurological Problems
- ☐ *Numbness*
- ☐ Orthotics/ Heel Lift
- ☐ *Osteoarthritis*
- ☐ Osteoporosis/ Osteopenia
- ☐ *Pacemaker*
- ☐ Paralysis
- ☐ *Parkinson's Disease*
- ☐ Physical Therapy
- ☐ *Pinched Nerve*
- ☐ Pranayama/ Breath Work
- ☐ *Pregnancy*
- ☐ PTSD
- ☐ *Rashes*
- ☐ Respiratory Problems
- ☐ *Rheumatoid Arthritis*
- ☐ Ringing in Ears
- ☐ *Sensitive to Touch/Pressure*
- ☐ *Shingles*
- ☐ Sit w/One Leg Under You
- ☐ *Sinus Problems*
- ☐ Skin Problems
- ☐ *Sleep Apnea*
- ☐ Spinal Problems
- ☐ Sprains/Strains
- ☐ *Stabbing Pain*
- ☐ Stress
- ☐ *Sound Baths*
- ☐ Surgery
- ☐ *Tobacco Use*
- ☐ TENS Unit
- ☐ *Thyroid Problem*
- ☐ Varicose Veins
- ☐ *Vibrational Sound Sessions*
- ☐ Vision Problems
- ☐ *Yoga*
- ☐ Yoga Nidra
- ☐ Yoga Therapy

Other Not Listed Above: _____

_____

POLICIES & CONSENT FOR MASSAGE/BODYWORK @ METTA Wellness Center:

I understand the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified 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 during the session 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, recommendations and/or restrictions on the part of my medical practitioner and understand that there shall be no liability 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 full payment of the scheduled appointment. Scheduled appointments will start and end on time.

All cancellations and/or rescheduling of massage/bodywork appointments require at least 72-hour notice or a $25 fee will be charged. HOWEVER, if cancelled/rescheduled within 24 hours of appointment, 50% of total service will be charged. NO SHOW appointments will be charged in full. ***These payments will be charged to credit card on file immediately.*** **Please cancel – even if it is just a few minutes before your scheduled appointment. Thank you so much for your cooperation and understanding.**

Lateness: If a client does NOT contact Deborah (by phone or text) about running late for an appointment, the session will be considered a no show after 30 minutes past appointment start time and charged accordingly. If a client is late, the therapist will give the most complete treatment possible in the time remaining. However, each treatment will be finished on time to accommodate the next client. If the client arrives too late for the therapist to perform the scheduled massage, the session will be charged at full rate.

The preferred method of notice is text or email (so both parties have written acknowledgment of cancellation/rescheduling). You can also leave a voicemail if text/email is not an option for you.

I confirm that I have not been in close contact with anyone exhibiting illness or COVID symptoms within the past 14 days. I further confirm that I am not currently living with anyone who is sick or who is quarantined. To prevent the spread of contagious viruses and to help protect each other, I understand that I will have to follow the practitioner's guidelines.

I acknowledge and agree to the above policies.

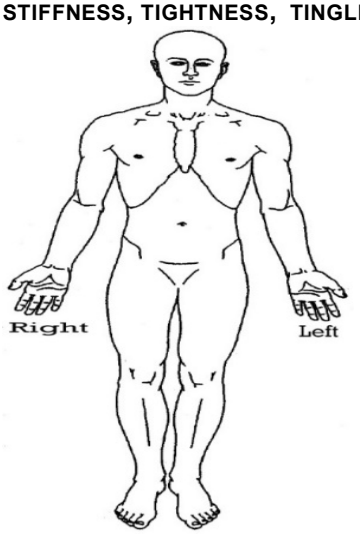
Signed: _____Date: ____/_____/_____

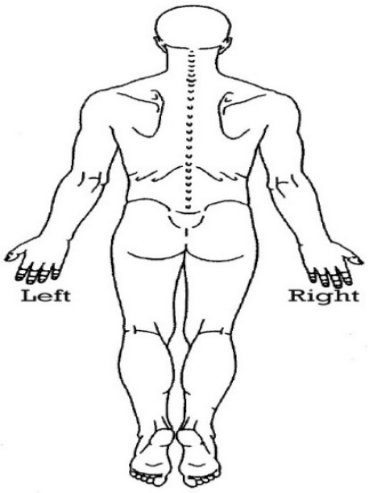
Consent to treatment of minor: I authorize massage be performed on my above-named child or dependent as deemed necessary by massage therapist.

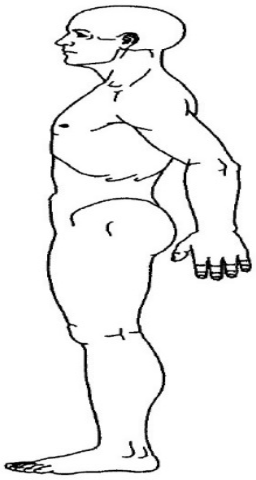
Parent/Guardian Signed: _____

Name: _____ **Date:** ____/____/202__

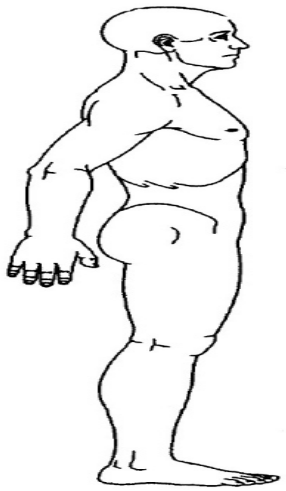
ON THE FOLLOWING PICTURES, PLEASE DRAW (NOT CIRCLE) PROBLEM AREAS (WITH RED PEN) YOU EXPERIENCE AND DESCRIBE THE SENSATION. EXAMPLE: KNOTS, NUMBNESS, PAIN, PAIN W/MOVEMENT REDUCED RANGE OF MOTION, SORE, STIFFNESS, TIGHTNESS, TINGLING, ETC.





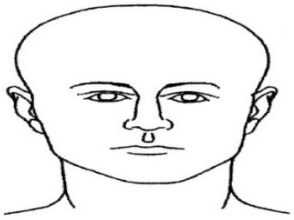


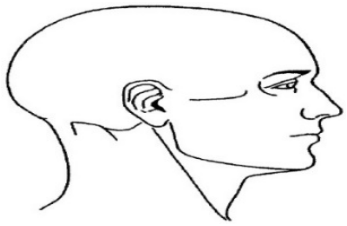
LEFT SIDE BODY



RIGHT SIDE BODY

LEFT SIDE HEAD





RIGHT SIDE HEAD

Any areas you would like me to spend **EXTRA** time on today? _____

PRESSURE today? ☐ Light ☐ Light/Medium ☐ Medium

☐ Medium/Deep ☐ Deep ☐ Very Deep ☐ No One EVER goes deep enough!!

Any areas you would ***NOT*** like massaged today? _____

I agree for my massage therapist to administer therapeutic massage to the following areas when necessary - understanding they may or may not be necessary in each treatment but in accordance with any musculoskeletal issues I may be having: gluteal muscles, pectoral muscles (chest – never breasts), groin (femoral triangle, gracilis and/or adductors), abdominal area (iliopsoas or the individual muscles that combine). I give my consent to undrape the area being worked on while providing complete privacy to my private areas (which will NEVER be exposed). I understand this is a therapeutic massage intended for better health and is NOT for any type of sexual gratification.

WHAT IS YOUR GOAL FOR TODAY'S SESSION?

☐ **CLINICALLY-FOCUSED** ☐ **GENERAL WELLNESS** ☐ **RELAXATION**

☐ Anxiety Relief ☐ Cramping ☐ Headaches ☐ Numbness/Tingling ☐ Pain Relief

☐ Restore Range of Motion ☐ Stress Relief ☐ Tight muscles/knots

☐ Other: _____

CLIENT SIGNATURE: _____ Date: ___/___/202__

STOP & RETURN FORM

SOAP Notes (To Be Completed By Therapist ONLY!!)

Client name: _____ Treatment Date: ___/____/202__

***S**UBJECTIVE INFORMATION (Client reported)*

***O**BJECTIVE INFORMATION (Objective Assessment)*

***A**CTION (Application) What kinds of treatment were used? Changes occur?*

***P**LAN of treatment/Progress*

Therapist's Signature: _____ **Date:** ____/_____/202__