



TMJ Relief & Therapy LLC

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate massage therapy treatment, we need you to complete the following questionnaire. All information is strictly confidential.

Client Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Occupation: _____

Home Address: _____ City: _____ State: _____ Zip: _____

☐ Home Phone : __ () _____ ☐ Cell Phone : __ () _____

How did you hear about us? _____

Have you ever had a professional massage before? ☐ Yes ☐ No

If yes, when was your last massage? _____

What type of massage? (ex. Swedish, Deep Tissue, etc?) _____

What type of pressure do you like? Please Check ☐ Light ☐ Medium ☐ Firm ☐ Deep

Are you uncomfortable with any of the following areas to be massaged:

___ Neck/ Shoulders ___ Pectoral Region ___ Face/Scalp

HEALTH HISTORY

Please list any medications or supplements you are currently taking and explain:

Please list any injuries/accidents/illnesses still affecting you:

Please list any surgeries and explain:

Please indicate any Present (P), Past (X), or Reoccurring (C) conditions:

☐ ADD/ADHD
☐ Allergies
☐ Alzheimer's Disease
☐ Anxiety Disorder
☐ Arthritis
☐ Osteoarthritis
☐ Rheumatoid Arthritis
☐ Athletes foot
☐ Asthma
☐ Blood Clot/Deep Vein Thrombosis
☐ Phlebitis/Embolism
☐ Broken or Fractured Bones
☐ Bursitis
☐ Cancer
☐ Location: _____
☐ Treatment: _____
☐ In Remission? _____
☐ Carpal Tunnel Syndrome
☐ Cerebral Palsy
☐ Chronic Fatigue Syndrome
☐ Contagious Condition
☐ Crohn's Disease
☐ Depression
☐ Diabetes
☐ Type 1
☐ Type 2
☐ Diverticulitis
☐ Eczema
☐ Epilepsy
☐ Epstein Barr
☐ Fertility Concerns
☐ General Fatigue
☐ Gout
☐ Headaches
☐ Type: _____
☐ Frequency: _____
☐ Hearing Impairment
☐ Heart Condition
☐ Herpes/Shingles
☐ High/ Low Blood Pressure
☐ High/Low Cholesterol
☐ HIV/AIDS
☐ Infection
☐ Lupus
☐ Lymphedema

☐ Mononucleosis
☐ Multiple Sclerosis
☐ Muscular Dystrophy
☐ Numbness/ Tingling
☐ Osteoporosis/Osteopenia
☐ Pain
☐ Location: _____
☐ Muscular or Joint: _____
☐ Chronic? _____
☐ Paralysis
☐ Parkinson's Disease
☐ Pregnancy
☐ Psoriasis
☐ Rash
☐ Sciatica
☐ Scoliosis
☐ Seizure
☐ Sleeping Problems
☐ Spasms/ Cramping
☐ Strain/ Sprain
☐ Stroke
☐ Tendonitis
☐ Throid Issues
☐ TMJ/ Jaw Pain
☐ Tumor
☐ Location: _____
☐ Malignant or Benign: _____
☐ Varicose Veins
☐ Visually Impaired
☐ Other: _____

☐ Respiratory Issues:
☐ COPD
☐ Use of CPAP?
☐ On Oxygen?

Release Form

By signing this, I agree that I have answered all questions to the best of my knowledge and that I will inform the therapist of any changes in my condition or medication. If I experience any pain/discomfort or would like the pressure adjusted, I will inform the therapist immediately.

I understand that a massage therapist cannot diagnosis any illness, disease, or any physical or mental disorders nor can the therapist prescribe any medication and that nothing said in a session should be construed as such. I understand that massage therapy is intended to work in conjunction with my health care, not act as a substitute for medical examination. I understand that it is my responsibility to consult a physician for any ailments I may have.

I understand that massage therapy is a therapeutic measure used to reduce stress, muscular tension, and pain. I understand there are no guarantees for recovery and if I am unsatisfied with the progress made with my treatment I will inform the therapist, so he/she may direct me to another treatment. I also understand that massage therapy is non-sexual in nature and any advancement made will terminate the massage.

I agree to abide by a 24 hour cancellation notice for any scheduled massage. I understand I may be charged up to the full amount of service for missed appointments or for any cancellations with less than a 24 hour notice. I understand that if I arrive late for an appointment, the session will end at the original scheduled time to prevent penalizing another client. However, if the massage therapist is late, he/she will fulfill the scheduled massage length or offer a reasonable compensation.

I understand that if I use a coupon during my visit, it is not valid with any other coupons or promotions.

I agree that I am of legal age (18 years old) and that if I am not, I agree to have my parent or guardian sign a parental/guardian release form before treatment.

I understand that certain conditions or medications may contraindicate (not permit) massage or may require the use of alternate techniques or pressure. I respect the decision of the massage therapist and am fully prepared to reschedule the massage for a later date if requested by the massage therapist. I also understand that massage may be advisable by my physician, but not by a massage therapist. In that event, I agree to provide a written agreement from my physician before proceeding with treatment.

Print Name: _____

Signature: _____

Date: _____