

PLEASE WRITE LEGIBLY

Personal Information and History

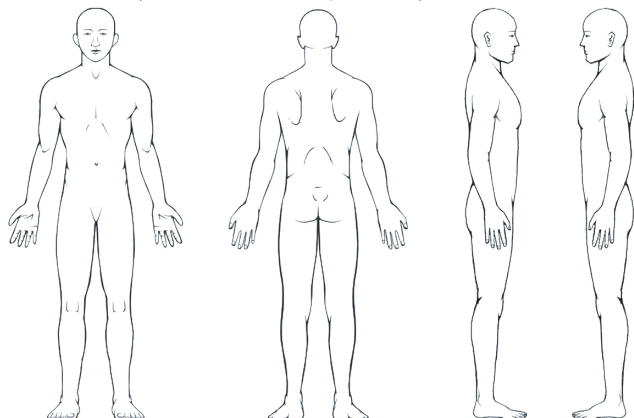
Name		Date of Birth	
Profession		Employer	
Primary AILMENT and/or DIAGNOSIS			
Rate your motivation to resolve this?	LOW <input type="checkbox"/> MODERATE <input type="checkbox"/> HIGH <input type="checkbox"/>	Current Medications?	
Previous ISSUES and TREATMENTS			
Which of these providers have you seen in the past?	Are you interested in a collaboration between Psoas and your other providers? Yes <input type="checkbox"/> No <input type="checkbox"/>		
		Name	Phone number
	<input type="checkbox"/> Physician	_____	_____
	<input type="checkbox"/> Chiropractor	_____	_____
	<input type="checkbox"/> Physical therapist	_____	_____
	<input type="checkbox"/> Personal trainer	_____	_____
<input type="checkbox"/> Acupuncturist	_____	_____	
<input type="checkbox"/> Other movement specialist/trainer(s)	_____	_____	

Have you received massage therapy before?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, please describe frequency and type:
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Currently Experiencing the Following? (✓all that apply)	Time/Focus Preferences - for a general session (✓all that apply)
<input type="checkbox"/> Pain (where?) _____ <input type="checkbox"/> Stabbing <input type="checkbox"/> Dull <input type="checkbox"/> Mobility issues <input type="checkbox"/> Numbness <input type="checkbox"/> Broken bones < 2 years <input type="checkbox"/> Injuries < 1 year <input type="checkbox"/> Sensitivity <input type="checkbox"/> Other _____	<input type="checkbox"/> Neck <input type="checkbox"/> Upper back / shoulder <input type="checkbox"/> Lower back <input type="checkbox"/> Hips <input type="checkbox"/> Upper leg(s) <input type="checkbox"/> Lower leg(s) <input type="checkbox"/> Knee(s) <input type="checkbox"/> Ankle <input type="checkbox"/> Feet
<input type="checkbox"/> Fatigue <input type="checkbox"/> Headaches <input type="checkbox"/> Epilepsy <input type="checkbox"/> Pregnancy <input type="checkbox"/> Blood sugar issues <input type="checkbox"/> High blood pressure <input type="checkbox"/> Varicose veins <input type="checkbox"/> Bruise easily <input type="checkbox"/> Digestive issues	<input type="checkbox"/> Head <input type="checkbox"/> Face <input type="checkbox"/> Arm(s) <input type="checkbox"/> Hand(s) <input type="checkbox"/> Back of the body only <input type="checkbox"/> Front of the body only <input type="checkbox"/> Full body <input type="checkbox"/> Full body with some focus <input type="checkbox"/> Other _____

Treatment Preferences

Please circle any areas of tension or pain that you would like addressed



What kind of pressure do you prefer?	<input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Deep
Are you currently in a maintenance massage program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you want self-care recommendations between treatments?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What would you like to achieve from your session today?	

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Contact Information

Name		Today's Date	
Email			
Street Address			
City		State	
Primary Phone		Zip	
	<input type="checkbox"/> mobile?		
Emergency Contact		Emergency Phone	

How Did You Hear About Us?

- Google
 Yelp
 SoMa Square
 One Medical
 Facebook
 Instagram
 Other: _____
 Current Client: _____
 Training Group/Membership: _____
 Medical/Healthcare Provider: _____

Appointment Confirmations

We provide a courtesy confirmation text or email; however each client is responsible for their scheduled appointment regardless of the confirmation receipt. **If 24-hour notice is not provided, the client is responsible for the full appointment fee.**

Please fill out confirmation preferences legibly:

- By Email _____
 By Text _____
 Do Not Contact Me To Confirm My Appointments

Weekly Specials and Available Appointments Emails

Every Monday and Friday morning we email the available appointment times for the coming week/weekend to existing clients first. This email includes special Psoas offers.

- Yes, I would like to receive email notices of specials and appointment times.
 No, I prefer not to be emailed for this.

Quick Tip Emails

Every other Wednesday, we send out a Quick Tip — a stretch, exercise or anatomy lesson to support you between sessions.

- Yes, I would like to receive the Quick Tip emails.
 No, I would not like to receive the Quick Tip emails.

Acknowledgment and Consent to Receive Services

I understand that massage/bodywork should not be construed as a substitute for medical examination and that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness. I understand that massage/bodywork is contraindicated under certain medical conditions. Therefore, 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 as represented by me, and understand that there shall be no liability on the practitioner's part should I fail, for whatever reason, to do so.

Signed: _____

Date: _____