



Amelia Mitchell, CMT

Nurture the Essential  
New Client Information

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Birth Date \_\_\_\_\_

Email Address \_\_\_\_\_ May I add you to my mailing list? \_\_\_\_\_

Telephone # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

Emergency Contact - Name \_\_\_\_\_ Phone# \_\_\_\_\_

How did you learn about me? \_\_\_\_\_

Have you received Professional Massage Therapy or Bodywork before? \_\_\_\_\_

What Kinds? \_\_\_\_\_ How often? \_\_\_\_\_

- Please check off any of the following conditions or symptoms which apply to you now or in the past:
- |  |  |  |
|--|--|--|
| <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Blood Clots           | <input type="checkbox"/> Muscle Sprain / Strain    |
| <input type="checkbox"/> Contact Lens            | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Heart Attack / Stroke     |
| <input type="checkbox"/> Low Back Pain           | <input type="checkbox"/> Varicose Veins        | <input type="checkbox"/> Arthritis                 |
| <input type="checkbox"/> Allergies (please list) | <input type="checkbox"/> Bursitis              | <input type="checkbox"/> Headaches - Migraines     |
| <input type="checkbox"/> Osteoporosis            | <input type="checkbox"/> Skin Infections       | <input type="checkbox"/> Constipation/Irregularity |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Hypo or Hyperglycemia | <input type="checkbox"/> Hormonal Changes          |
| <input type="checkbox"/> Pregnant                | <input type="checkbox"/> Contagious Conditions | <input type="checkbox"/> Other Conditions          |

Details for items checked above \_\_\_\_\_

Surgeries? \_\_\_\_\_

Are you currently experiencing any cold, flu-like, or other symptoms of infection? \_\_\_\_\_

Have you had any serious or chronic illness or traumatic accidents? \_\_\_\_\_

If yes, please give dates and details: \_\_\_\_\_

\_\_\_\_\_

Please list and explain other conditions/symptoms you are or have experienced:

\_\_\_\_\_

**OVER PLEASE**

Do you have a history of cancer? \_\_\_\_\_ If any surgery, were any lymph nodes removed? \_\_\_\_\_

Do you have a history of radiation therapy? \_\_\_\_\_ Do you have a history of lymphedema? \_\_\_\_\_

Are you currently, or have you at any time within the last 12 months been under the care of a physician?  
If yes, for what condition?

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Are you on any medication? \_\_\_\_\_ If yes, which ones, and what are they prescribed for?

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If appropriate, and with your knowledge, may I have permission to contact your Doctor / Therapist? \_\_\_\_\_  
Doctor / Therapist Name: \_\_\_\_\_ Telephone \_\_\_\_\_

#### Lifestyle

What forms of exercise do you enjoy regularly and how often ?

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How Much water do you drink each Day? \_\_\_\_\_

What are you passionate about? \_\_\_\_\_

What goals do you have for this session? \_\_\_\_\_

Is there anything else that I should know about you to best provide therapeutic massage and bodywork to you?

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I have completed this health form to the best of my knowledge. I understand that Massage Therapy and Bodywork, Lymphatic Drainage Therapy and CranioSacral Therapy services are a therapeutic health aid. They do not take the place of a physician's care when indicated.

Any information exchanged during a Massage or Bodywork session is confidential and is only used to provide you with the best health care services.

If I am not able to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case, I will call ASAP to reschedule my appointment within one week. If I miss a scheduled appointment without giving 24 hour notice, I agree to pay the full appointment as applicable.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Thank you for sharing this information, it is truly helpful.