The Relief Clinic
Massage Cupping & MediCupping

Steven Chapa LMT, CMCP

Today's Date _____ Gender (F) (M)

Preferred Pressure: (**Light**) (**Medium**) or (**Deep**)

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Phone (home) _____ (cell) _____ email _____

Occupation _____

Emergency contact (name & number) _____

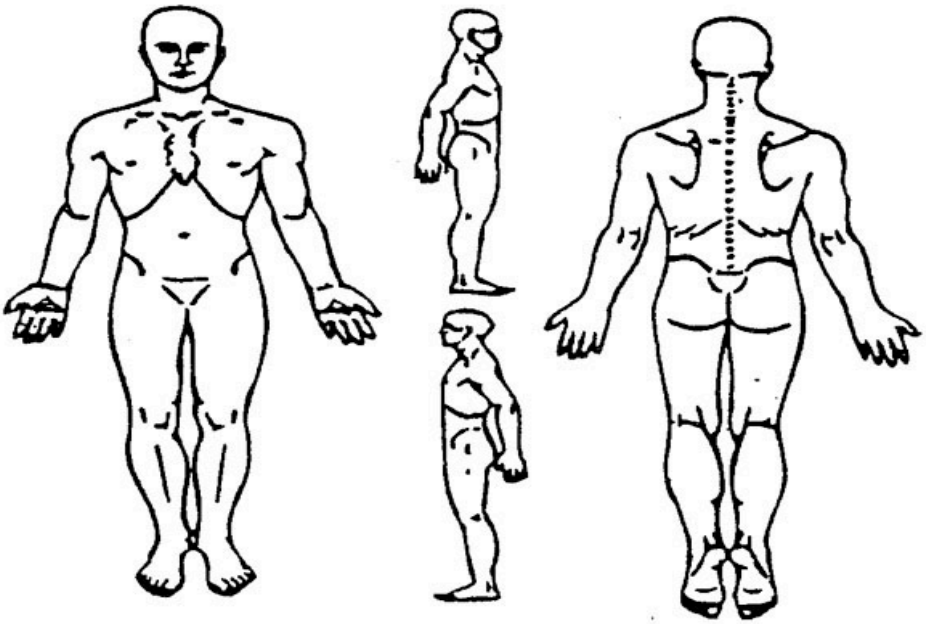
Referred by: _____

Have you had any major injury and/or surgery in the past or recently?
Please inform us. We may only massage a client 6 weeks AFTER surgery. Thank you!

_____

Are you currently in pain or experiencing any discomfort? If so, please briefly explain and indicate those areas below _____

Please highlight specific areas on body diagram!



Describe any chronic pain/tension_____

What makes it better? _____

What makes it worse? _____

Are you currently under the care of a physician, chiropractor or alternative medicine practitioner? If yes, what are you being treated for? _____

Please list any medications (prescription or non-prescription), vitamins and supplements you are currently taking: _____

Are you currently receiving any other body or energy therapies? _____

If yes, what for? _____

What specific areas would you like the therapist to focus on or stay away from? _____

Are there any areas you do NOT like massaged (i.e. feet, stomach, head, face)? _____

What do you hope to accomplish with this massage? (i.e. relaxation, decrease back pain, increase flexibility, etc.) _____

Please check any of the following that apply to you in the past or present::

Condition/Complaint	Past	Present	Condition/Complaint	Past	Present
Headaches Type:			**Pins and Needles in arms, legs, Hands or feet or Numbness**		
Asthma			**Neurological problems**		
Cold Hands/feet			**Spinal Problems**		
Swollen ankles			**Herniated/Bulging Discs**		
Sinus Conditions			**Osteoarthritis**		
Frequent Colds			**Arthritis**		
Allergies (specify above)			**Anxiety**		
Loss of smell/taste			**Depression/Panic**		
Skin Conditions			**Sleep Disturbance**		
Painful/Swollen Joints			**Loss of Memory**		
Auto-immune disorder			**Whiplash**		
Cancer			**Bruise Easily**		
Varicose Veins			**Constipation/Diarrhea**		
Blood Clots/DVT			**Contact Lenses**		
Heart Problems			**Dentures/Partials**		
Pacemaker			**Hemorrhoids**		
High/Low BP			**Artificial/Missing limbs**		
Diabetes			**Muscular Tension**		
Epilepsy or Seizures			**Sciatica**		
Fainting Spells			**Pregnant**		

Please specify/circle if you have any of the following: (Autoimmune Disorders), (Multiple Sclerosis,) (Sickle Cell Disease in acute phase), (Hepatitis), (Infectious Conditions: ringworm, scabies, infectious diarrhea, The Flu, Fever, Cold), (Gallstones), (Pericarditis).

*Further explanation of any condition or other information:*_____

The following sometimes occurs during massage; they are normal responses to relaxation. Trust your body to express what it needs:

☯*Need to move or change positions* ☯*Sighing, yawning, change in breath* ☯*Stomach gurgling*
☯*Emotional feelings and/or expressions* ☯*Movement of intestinal gas*
☯*Energy shifts* ☯*Falling asleep* ☯ *Memories*

- I understand the treatment here is not a replacement for medical care.
- As such, the therapist/practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform any spinal manipulations (unless specified under his/her professional scope of practice.)
- I understand that the treatment is not a substitute of medical treatments and/or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have.
- I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.
- I understand that payment is due at the time of treatment unless arrangements have been made otherwise.
- It is also understood that any illicit of sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment for the full scheduled appointment.

What to expect as part of my therapy at The Relief Clinic?
Hands on therapy, Massage Cupping, MediCupping, Percussion, Infrared, Hot Lava Shell, Aromatherapy, Acupressure MagneticTherapy and Myofascial Release. Used as needed.

Privacy Policy:
All written records and massage sessions are kept strictly confidential and will not be shared with any outside establishment, individuals, organizations or medical facilities without explicit written consent from the client (you) or the client's legal guardian. unless legally required by local, state or federal subpoena, summons, or other court order.

- **I agree to give at least 24 hours notice of cancellation of appointment, otherwise will be expected to pay for full session.**
  PLEASE INITIAL _____

Client signature_____
Date_____