(Please initial next to each clause) I, _____, have received, read and understand the PMTI Clinic Welcome Letter and HIPAA Privacy Policy and affirm that:

_____ I understand that massage is not a substitute for medical examination, diagnosis or treatment. There are certain conditions for which massage may be contraindicated. I have given a complete health history to the best of my knowledge, and I agree that I will not hold Potomac Massage Training Institute liable for any effects from my sessions in the Clinic.

_____ I understand that massage at the PMTI Clinic is strictly non-sexual. Lewd or sexual language or behavior will not be tolerated and will result in the immediate termination of the session. I also understand that I will still be responsible for full payment of the session and will not be able to make future appointments at the PMTI Clinic.

_____ I understand that if I am late to my appointment I may not receive the full allotted time of my session and that I am still responsible for full payment of the session. Additionally, if I am more than 20 minutes late in the **Student Clinic**, my session may be given to another client and I will still be responsible for full payment.

_____ I understand that there is a 24 hour cancellation policy. For cancellations made after the deadline, I am responsible for full payment of my session. I understand that cancellations may be made over the phone with front desk staff or via voicemail.

*Client Signature*_____*Date*_____

*Witnessed:*_____*Date*_____

Updated 05-08-13

HEALTH INTAKE FORM

Client Name_____Today's Date_____
Address_____
City_____ State _____ Zip code_____
Home Phone:_____ Work Phone: _____
Cell Phone: _____ Email: _____
Occupation_____Birth Date __/__/__ Gender_____
Referred by_____

1. What are you hoping to gain from massage?_____
   _____
2. Have you ever had a professional massage/bodywork? Yes No
   If so, what kind(s)?_____
3. Are you presently under a doctor's or therapist's care? Yes No
   If so, for what_____
4. Please list current symptoms:_____
   _____
5. Please list any medications you are taking:_____
   _____
   What side effects, if any, do you experience?_____
   _____
6. Do you smoke? YES NO
7. Do you have any allergies? YES NO If so, to what?_____
8. Are you wearing: **Contact Lenses** YES NO **Hearing Aids** YES NO
9. Are you pregnant? YES NO If so, what is your due date?_____
10. What kind of exercise do you do regularly?_____
    _____How often?_____

11. Are you experiencing or recovering from any of the following **TODAY**?

Skin Rash Open cuts/sores Injuries/Bruises Allergies/Cold/Flu/Fever

Mononucleosis Hepatitis Stress Fatigue Digestive Problems

Other virus/infection _____

12. Are you experiencing any pain today? YES NO

If yes, how long have you had this pain?_____

If yes, please circle and rate the amount of pain sensation and unpleasantness on the scales below:

Pain Sensation: How much pain you feel physically in your body

0 1 2 3 4 5 6 7 8 9 10

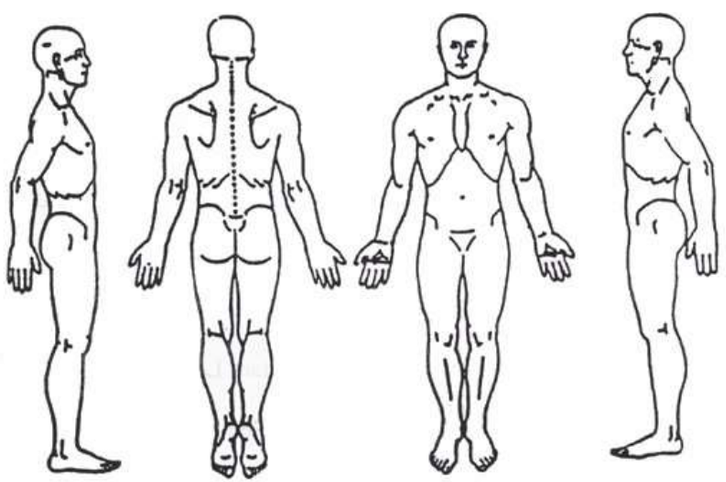
No pain Most pain possible

Pain Unpleasantness: How much of the pain in your body bothers you

0 1 2 3 4 5 6 7 8 9 10

No unpleasantness Most unpleasantness possible

Use the diagram to map your discomfort by circling the body parts that apply.



Please circle any of the following which you currently have or have experienced in the past, indicating the dates in the space provided if necessary.

Musculoskeletal
Arthritis
Back pain
Foot pain
Fracture
Herniated Disk
Osteoporosis
Torn ligament/tendon
Scoliosis
Sports injury
Strain/sprain
Whiplash
Other _____

Psychiatric
Anxiety Disorder
Bipolar
Depression
Frequent stress
Mood swings
PTSD
Sleep Disorders
Other _____

Respiratory
Asthma
Bronchitis
COPD
Emphysema
Hay Fever
Other _____

Cardiovascular:
Blood clots
Heart attack
Heart disease
High blood pressure
Low blood pressure
Phlebitis
Poor circulation
Stroke
Varicose veins
Other _____

Urinary
Frequent urination
Difficult/painful urination
Kidney stones
UTIs
Other _____

Digestive
Colitis
Constipation
Crohn's disease
Diarrhea
Other _____

Neurological:
Fibromyalgia
Headaches
Migraines
Numbness/tingling
Sciatica
Other _____

Endocrine
Diabetes
Hypo/Hyperglycemia
Other _____

Skin Infections
Burns
Eczema
Impetigo
Other _____

Reproductive
Dysmenorrhea
Fibroid Cysts
Infertility
PMS
Prostatis
Other _____

Cancer: Please describe type and stage_____
_____
_____

Surgeries: Please include dates _____
_____
_____