

BluCoral Fit Sports Muscle Release Intake Form

Personal Information:

Name _____ Phone (Day) _____ Phone (Eve) _____

Address _____

City/State/Zip _____

email _____ Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

**The following information will be used to help plan safe and effective massage sessions.
Please answer the questions to the best of your knowledge.**

Date of Initial Visit _____

1. Have you had a professional massage before? Yes No

If yes, how often do you receive massage therapy? _____

2. Do you have any difficulty lying on your front, back, or side? Yes No

If yes, please explain _____

3. Do you have any allergies to oils, lotions, or ointments? Yes No

If yes, please explain _____

4. Do you have sensitive skin? Yes No

5. Are you wearing contact lenses () dentures () a hearing aid () ?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No

If yes, please describe _____

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No

If yes, please describe _____

8. Do you experience stress in your work, family, or other aspect of your life? Yes No

If yes, how do you think it has affected your health?

muscle tension () anxiety () insomnia () irritability () other _____

9. Is there a particular area of the body where you are experiencing tension, stiffness, pain

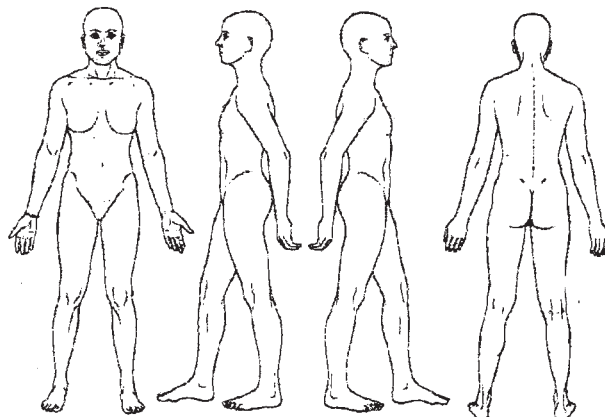
or other discomfort? Yes No

If yes, please identify _____

10. Do you have any particular goals in mind for this SMR session? Yes No

If yes, please explain _____

Circle any specific areas you would like to concentrate on during the session:



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BluCoral Fit[®]

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Medical History

In order to plan a Sports Muscle Release (SMR) session that is safe and effective, I need some general information about your medical history.

11. Are you currently under medical supervision? Yes No

If yes, please explain _____

12. Do you see a chiropractor? Yes No If yes, how often? _____

13. Are you currently taking any medication? Yes No

If yes, please list _____

14. Please check any condition listed below that applies to you:

- | | |
|---|--|
| <input type="checkbox"/> contagious skin condition | <input type="checkbox"/> phlebitis |
| <input type="checkbox"/> open sores or wounds | <input type="checkbox"/> deep vein thrombosis/blood clots |
| <input type="checkbox"/> easy bruising | <input type="checkbox"/> joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis |
| <input type="checkbox"/> recent accident or injury | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> recent fracture | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> recent surgery | <input type="checkbox"/> headaches/migraines |
| <input type="checkbox"/> artificial joint | <input type="checkbox"/> cancer |
| <input type="checkbox"/> sprains/strains | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> current fever | <input type="checkbox"/> decreased sensation |
| <input type="checkbox"/> swollen glands | <input type="checkbox"/> back/neck problems |
| <input type="checkbox"/> allergies/sensitivity | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> heart condition | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> high or low blood pressure | <input type="checkbox"/> carpal tunnel syndrome |
| <input type="checkbox"/> circulatory disorder | <input type="checkbox"/> tennis elbow |
| <input type="checkbox"/> varicose veins | <input type="checkbox"/> pregnancy If yes, how many months? |
| <input type="checkbox"/> atherosclerosis | |

Please explain any condition that you have marked above _____

15. Is there anything else about your health history that you think would be useful for your SMR Staff to know to plan a safe and effective Sports Muscle Release session for you? _____

Draping my be used during the session – only the area being worked on will be uncovered, if needed.

Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session.

Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, _____ (print name) understand that the Sports Muscle Release, I receive is provided for the basic purpose of relaxation and release of muscle tension. If I experience any pain or discomfort during my session, I will immediately inform the person doing my Sports Muscle Release session that the pressure, strokes or stretching may be adjusted to my level of comfort. I further understand that Sports Muscle Release should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that the Sports Muscle Release should not be performed under certain medical conditions. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the staff updated as to any changes in my medical profile and understand that there shall be no liability on the staffs (BluCoral Fit) part should I fail to do so.

Signature of client _____ Date _____