re-org Client Information

Name: ___________________________ Date: ______________
Phone: ___________________________ Email: ___________________________
Address:____

Medical History
Please take a moment to carefully read through the following questions and answer to the best of your knowledge. Some specific conditions or symptoms may be contraindicated. A referral from your primary care provider may be required.
•Please list any conditions for which you currently undergoing medical treatment:
____
•Please list any medications you are currently taking:
____

•Do you have any contagious diseases?	Y	N
•Do you have any current injuries?	Y	N
•Are you pregnant?	Y	N
•Do you frequently suffer from stress?	Y	N
•Do you experience frequent headaches?	Y	N
•Do you have high blood pressure?	Y	N
•Do you have allergies?	Y	N

If you answered yes to any of the questions above, please provide a thorough explanation of your situation:
____
____
____
____
____

Massage History

Have you had massage therapy before?	Y	N
If yes, was it a positive experience?	Y	N

Please briefly explain what you liked/disliked about the experience:
____
What outcomes would you like to achieve with your sessions?
____
____

1219 E. 11th Ave Denver, CO 80218 720.837.5223 contact@re-orgdenver.org

re-org Client Commitment Form

For some specific medical conditions, massage therapy may be contraindicated. By signing this form, I understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis or treatment. I affirm that I have stated all known medical conditions and answered all of the questions on my intake form honestly.

I understand that it is my right and responsibility to inform the therapist if I experience any pain or discomfort during the session, and that the therapist should adjust the level of pressure immediately. If I do not feel comfortable with my massage therapist, I will report the issue to the re-org office immediately.

I understand that this therapist provides a non-sexual environment and any inappropriate language or contact will not be tolerated.

I understand that this therapist has the right to terminate the session at any point in time if deemed necessary by the therapist.

____________________________________ ____________________
Client Signature Date

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Physician Approval Form

Patient Name: ____

Diagnosis: ______________________ Date of diagnosis: __________________

Treatment(s) received: ____

Current status of patient: ____

Date that patient finished treatment: ________________________

I confirm that the above information is complete and correct. I give my approval for this patient to receive massage therapy.

Physician Name (print): _________________________ Phone: _______________

Physician Signature: ___________________________ Date: ________________