Ruth Fuller-Ochoa, CMT

Name: ____ Date of Birth: _______________

Phone: _______________________________ Email: __________________________________

Address: ____

Referred By: ___________________________________

Emergency Contact: ______________________________ Phone: ________________________

Reason for Initial Visit: ____

What are your goals for treatment?

____

____

____

Occupation: ____

Current Medications: ____

____

____

Balanced Body

MYOFASCIAL RELEASE

Ruth Fuller-Ochoa, CMT

Have you ever had surgery? Please list dates and procedures:

Have you had any car accidents, broken bones or serious injuries?

Please Mark All that Apply:

- ☐ Diabetes
- ☐ Heart Problems
- ☐ High or Low Blood Pressure
- ☐ Pregnant or Nursing
- ☐ Headaches/Migraines
- ☐ Vision or Hearing Problems
- ☐ Autoimmune Disorder
- ☐ Numbness or Shooting Pains
- ☐ Contagious Diseases

Any other pertinent health information:

Balanced Body

MYOFASCIAL RELEASE

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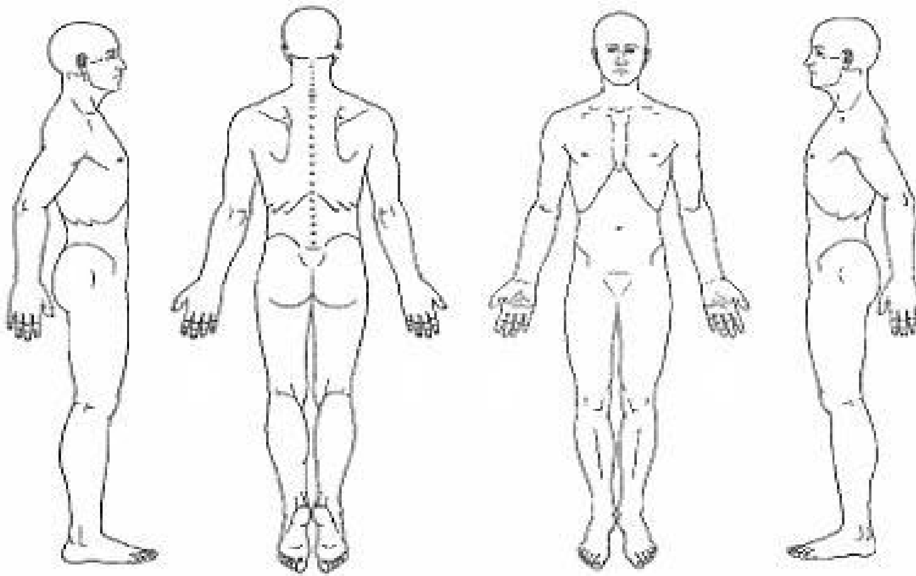
Please Mark All Areas You are Experiencing Pain:



I am aware of the risks and benefits of receiving massage and myofascial release therapy. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes to my health. I understand the cancellation policy and agree to give 24 hours' notice to cancel any appointments, otherwise full payment is due.

Signature: ______________________________________ Date: ________________________

Consent to Treat Minor : __________________________ Date: ________________________
(Parent's Signature)