

**Beckie Campbell, LMT**

PO Box 525  
Seneca, MO 64865

417-776-2220  
Fax 776-2228

**Client Information**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Referred by \_\_\_\_\_ Phone \_\_\_\_\_

In Case of Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Age \_\_\_\_\_  Male  Female

Physician \_\_\_\_\_

Have you ever experienced a professional massage or bodywork session?  Yes  No

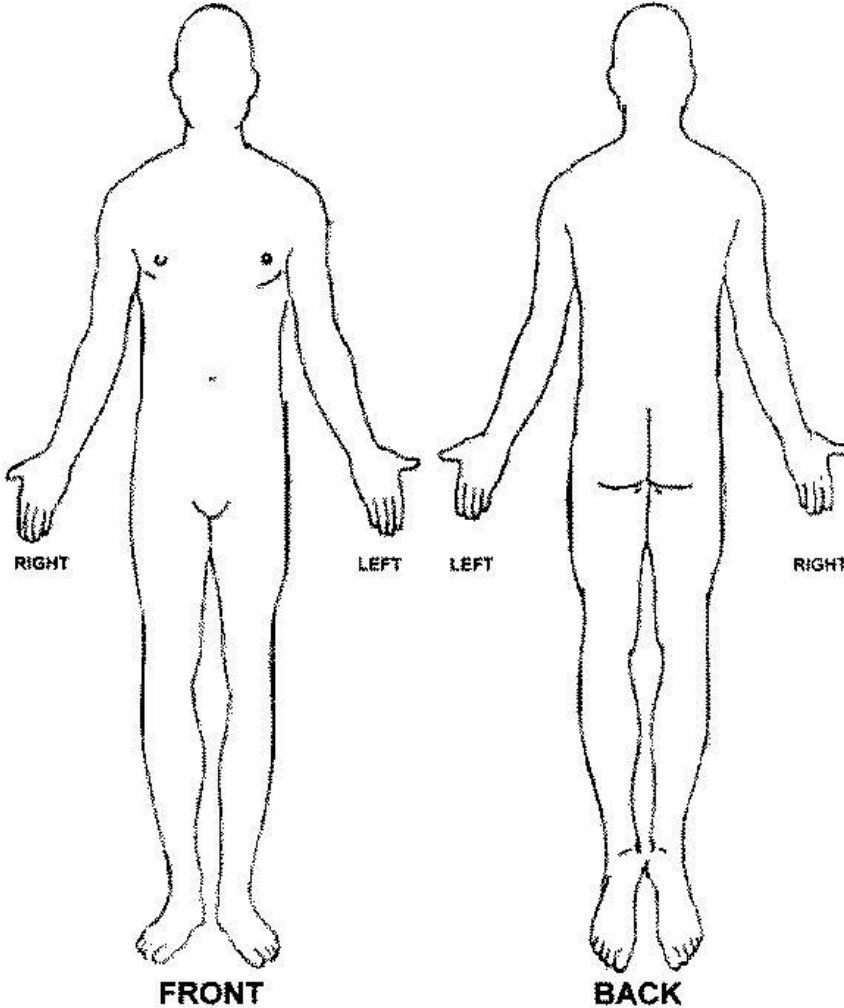
How recently? \_\_\_\_\_

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you frequently suffer from stress?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have tension or soreness in a specific area? Please specify:<br>_____                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have diabetes?  |  |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you experience frequent headaches?  |  |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you pregnant?  |  |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you suffer from arthritis?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have cardiac or circulatory problems?   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you wearing contact lenses?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you suffer from back pain?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you wearing dentures?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have numbness or stabbing pains anywhere?   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have high blood pressure?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you very sensitive to touch or pressure in any area?                                       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, to previous question, are you taking medication for this?            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you had surgery in the past five years? Explain: _____                                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you suffer from epilepsy or seizures?                                     |  |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you suffer from joint swelling?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have any other medical conditions or are you taking any medication I should know about? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have varicose veins?  |  |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes to previous question, have you had surgery to correct the problem?    |  |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have any contagious disease?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have osteoporosis?  |  |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have any allergies?   |  |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you bruise easily?  |  |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you had any broken bones in the past two years?                         |  |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you been in an accident or suffered any injuries in the past two years? |  |  |

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAIN DIAGRAM**

Please mark the areas where you feel the following sensations. Pay attention to right and left sides.

<b>Ache</b> ^^^^^ ^^^^^ ^^^^^	
<b>Numbness</b> OOOO OOOO OOOO	
<b>Pins &amp; Needles</b> ===== ===== ===== =====	
<b>Burning</b> XXXX XXXX XXXX	
<b>Stabbing</b> /////	

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/ or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should no be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a medical, osteopathic, or chiropractic physician for any mental or physical ailment that I am aware of. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustment, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client (or guardian of minor child) signature: \_\_\_\_\_ Date \_\_\_\_\_

Practitioner signature: \_\_\_\_\_ Date \_\_\_\_\_

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**Acknowledgment Form**

I acknowledge that I have read and understand the Notice of Privacy Rights that is posted both in Oxford Chiropractic Center and on their website. I understand that this notice also applies to all massage clients of Beckie Campbell, LMT. I give my permission to Beckie Campbell, LMT and Oxford Chiropractic Center to use and disclose my health information in accordance with said notice.

Printed name of patient \_\_\_\_\_

Signature of patient or guardian of minor child \_\_\_\_\_

Date \_\_\_\_\_

*\* This Authorization will expire in two (2) years from the above date unless written revocation is received*