Kristin Taravella, CCMT (415) 225-2016

CLIENT INFORMATION FORM
CROSSFIBER CORRECTIVE MUSCLE THERAPY®

Name _____ Email _____
Address _____
City _____ State _____ Zip _____
Telephone (home) _____ (work) _____ (cell) _____
Occupation _____ Employer _____
Physician _____
Birth Date _____ Referred by _____
Primary Reason for appointment _____

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING THE APPROPRIATE ANSWER:

- Have you had professional massage/ muscle therapy before? YES/NO
- Have you ever had surgery? If YES, please describe: _____ _____ YES/NO
- Do you wear contact lenses? YES/NO
- Do you wear dentures or other appliances? YES/NO
- Do you have any skin problems or allergies to lotions or oils? YES/NO
- Do you take any prescribed medication? If YES, please list: _____ _____ YES/NO
- Have you suffered an acute injury recently? YES/NO
- Do you have phlebitis or a history of phlebitis? YES/NO
- Do you have blood clots or a history of blood clots? YES/NO
- Have you had lymphatic problems or surgery? YES/NO
- Do you or have you had any heart problems? YES/NO
- Do you or have you had any spinal problems? If YES, what was the diagnosis? _____ _____ YES/NO
- Do you have blood pressure problems? YES/NO
- Do you exercise regularly or participate in any sports? If YES, what kind and how often? _____ _____ YES/NO
- Are you pregnant? YES/NO
- Do you have any other medical condition that I should be aware of before administering muscle therapy on you? If YES, please specify:_____ YES/NO

I, _____, understand that the Crossfiber Corrective Muscle Therapy given here is for the purpose of addressing muscle and soft-tissue damage, tension, spasm and entrapment, etc.

I understand that the Crossfiber Corrective Muscle Therapist (CCMT) does not diagnose illness, disease, or any other physical or mental disorder. As such, the CCMT therapist does not prescribe medical treatment or pharmaceuticals, nor does he/she perform any spinal manipulations. I understand that muscle therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Because the CCMT therapist must be aware of existing conditions, I have stated all my known medical conditions and take it upon myself to keep the CCMT therapist updated on any changes in the status of my health.

SIGNATURE:_____ Date_____

WITNESS:_____ Date _____