Massage and Myokinesthetic System Client Information Form

Purpose: This form gathers details about your posture. movement limitations, and nerve-related symptoms. Your responses help.Shela design an accurate and effective Mydkinesthetic treatment plan.

Client Information

Full Name _____

Date of Birth _____

Phone/Emall _____

Emergency Contact _____

2. Surgeries or Injuries Affecting Movement

_____

_____

_____

4. Movement Limitations

_____

_____

_____

5. Additional Notes

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1. Pain Patterns

- ☐ Neck/Shoulders
- ☐ Upper Back
- ☐ Lower Back
- ☐ Arms
- ☐ Legs
- ☐ Hips
- ☐ Other _____

3. Postural Concerns

- ☐ Uneven Shoulders
- ☐ Forward Head Posture
- ☐ Hip Imbalance
- ☐ Rounded Upper Back
- ☐ Scoliosis
- ☐ Other _____

Additional details or observations

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Descr share any restrictions in your movement, flexibility, or strength.

_____

Client Signature _____ **Date** _____