

CONTACT INFORMATION AND MEDICAL HISTORY

Name: _____ Date: _____

Referred by: _____ Therapist: _____

Address: _____ Date of Birth: _____

Sex: Female Male

Email: _____

Phone: Home: _____ Work: _____ Cell: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

HEALTH CARE PROVIDERS

Who is your primary health care provider? Physician Name and Title: _____

Address: _____ Phone: _____ Fax: _____

Other Providers :

Name and Title: _____ Phone: _____

Name and Title: _____ Phone: _____

Name and Title: _____ Phone: _____

MESSAGE INFORMATION

Have you ever received a massage? Yes No If yes, when was your last? _____

What is the reason for your visit? _____

What kind of pressure do you prefer (light, deep, moderate, etc.) _____

Do you have any areas of great sensitivity? _____

HEALTH HISTORY

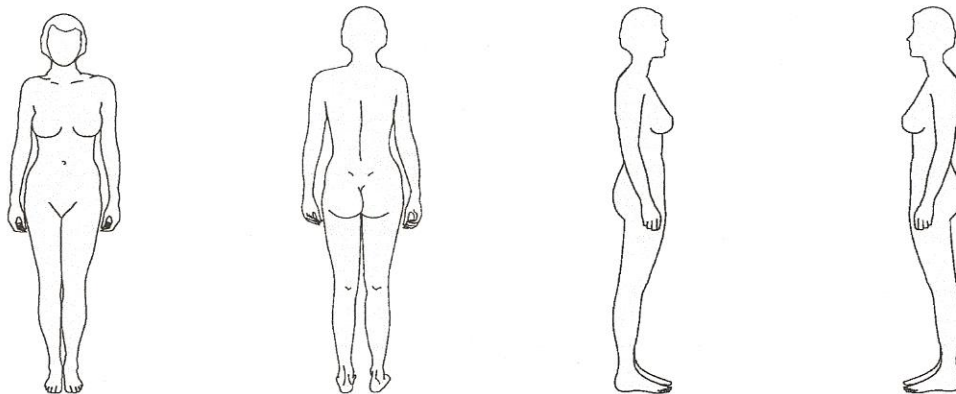
Please list typical daily activities — work, exercise, stress reduction, and other. _____

List any surgeries within the last 10 years, including date and treatment. _____

List any injuries within the last 10 years, including date and treatment. _____

Do you feel you have recovered from these events? If not, please explain. _____

Do you have tension or pain in particular areas? Please mark on the figures using the key provided.



KEY:

○ pain

✕ stiffness

⚡ numbness/tingling

bruises/open wounds

What makes your condition better? What makes it worse? _____

Does your condition interfere with work, home life, sleep or recreation? Please explain. _____

What treatment are you receiving or have you received for this condition? _____

List current medications including pain relievers. _____

Please check current or previous conditions:

MUSCULO-SKELETAL

- | Yes | No | |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Scoliosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Bone fracture |
| <input type="checkbox"/> | <input type="checkbox"/> | Tendonitis, bursitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache |
| <input type="checkbox"/> | <input type="checkbox"/> | Lupus |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle cramps |
| <input type="checkbox"/> | <input type="checkbox"/> | Sprains, strains |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Back pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip, leg pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck, shoulder, arm pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Stiffness |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling |

Other _____

SKIN

- | Yes | No | |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Cuts, burns, bruises |
| <input type="checkbox"/> | <input type="checkbox"/> | Rashes |
| <input type="checkbox"/> | <input type="checkbox"/> | Athletes foot |
- Other _____

DIGESTIVE

- | Yes | No | |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritable bowel syndrome |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain |
- Other _____

NERVOUS SYSTEM

- | Yes | No | |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness/tingling |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/ringing in ears |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes/shingles |
- Other _____

CIRCULATORY

- | Yes | No | |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Varicose veins |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood clots |
| <input type="checkbox"/> | <input type="checkbox"/> | High, low blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Lymphedema |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |

Other _____

OTHER

- | Yes | No | |
|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Cold, flu, contagious illness |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression, anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> | PMS |
| <input type="checkbox"/> | <input type="checkbox"/> | Currently Pregnant |
- If yes, due date _____

Do you have allergies? To what? (nuts, fragrances, etc.) _____

Are you wearing dentures? Yes No Contact lenses? Yes No

Is there anything else you can tell me that will help me understand how I can best help you? _____

CONSENT AND AUTHORIZATION FOR TREATMENT

PLEASE READ CAREFULLY AND SIGN

It is my choice to receive massage therapy. I realize that massage is being given for the well-being of my body and mind. I agree that:

If I experience pain or discomfort during a session, I will immediately inform my massage practitioner so that the pressure or strokes may be adjusted to my comfort level.

Because massage should not be done in conjunction with certain medical conditions, I have stated all my known illnesses and conditions, and will keep my practitioner updated as to changes in my health.

Initial: _____

I give permission to consult with my health care providers. Yes No Initial: _____

I realize that massage practitioners do not diagnose disease, or provide medical treatment. I understand that massage is not a replacement for medical diagnosis, and I should see a physician or other qualified medical specialist for any medical or physical ailment I am aware of. I give my consent for treatment.
Initial: _____

24 hours notice is required for appointment cancellations that are not due to emergency situations.

Signature _____ Date _____

Print Name _____