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: _____

MASSAGE 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. _____

_____

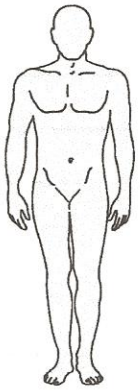
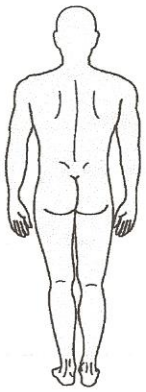
List any injuries within the last 10 years, including date and treatment. _____

_____

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:

O *pain*

X *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	
❑	❑	Arthritis
❑	❑	Osteoporosis
❑	❑	Scoliosis
❑	❑	Bone fracture
❑	❑	Tendonitis, bursitis
❑	❑	Headache
❑	❑	Lupus
❑	❑	Muscle cramps
❑	❑	Sprains, strains
❑	❑	Jaw pain
❑	❑	Back pain
❑	❑	Hip, leg pain
❑	❑	Neck, shoulder, arm pain
❑	❑	Stiffness
❑	❑	Swelling

Other_____

SKIN

Yes	No	
❑	❑	Cuts, burns, bruises
❑	❑	Rashes
❑	❑	Athletes foot

Other_____

DIGESTIVE

Yes	No	
❑	❑	Constipation
❑	❑	Irritable bowel syndrome
❑	❑	Abdominal pain

Other_____

NERVOUS SYSTEM

Yes	No	
❑	❑	Numbness/tingling
❑	❑	Dizziness/ringing in ears
❑	❑	Herpes/shingles

Other_____

CIRCULATORY

Yes	No	
❑	❑	Heart disease
❑	❑	Varicose veins
❑	❑	Blood clots
❑	❑	High, low blood pressure
❑	❑	Lymphedema
❑	❑	Shortness of breath
❑	❑	Asthma

Other_____

OTHER

Yes	No	
❑	❑	Cold, flu, contagious illness
❑	❑	Cancer
❑	❑	Diabetes
❑	❑	Depression, anxiety

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 conjuntion 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 _____