

Full Name

Email Address #

Date of Birth

Home Phone #

Work Phone #

Referred By

Mobile Phone #

Mailing Address

Emergency contact name

City

Emergency contact relationship

State

Zip Code

Emergency phone #

Physician's name

Physician's phone #

Date of initial visit:

How would you rate your
general health?

- Excellent Good
 Fair Poor

Have you had a professional
massage before?

- Yes (Date of last treatment) _____
 No

List current medications & the conditions they are treating

List any major accidents or surgeries (including dates)

Please tell us about any allergies or hypersensitivities

Reason for initial visit

Head Neck

- | | |
|--|--|
| <input type="checkbox"/> Headaches/migraines | <input type="checkbox"/> Vertigo/dizziness |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Vision loss |

Respiratory

- | | |
|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Family history of respiratory difficulties | |

Nervous System

- | | |
|--|---|
| <input type="checkbox"/> Sensory loss/change | <input type="checkbox"/> Numbness/tingling |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Multiple sclerosis |

Musculoskeletal system

- | | |
|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Family history of arthritis |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Jaw pain (TMJ) |
| <input type="checkbox"/> Pins/plates/wires / artificial joint | |

Reproductive

- Pregnant
- Gynecological problems
- Given birth

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

Treatments may be covered by extended health care plans. I understand that it is my responsibility to confirm the exact details of my coverage.

Signature:

Cardiovascular

- | | |
|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Phlebitis/varicose veins | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Hemophilia | |
| <input type="checkbox"/> Chronic congestive heart failure | |
| <input type="checkbox"/> Family history of cardiovascular problems | |

Skin & Infections

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Lyme disease | <input type="checkbox"/> Infectious skin conditions |

Other conditions

- | | |
|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Digestive conditions |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Chronic fatigue syndrome |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Psychiatric disorder | |
| <input type="checkbox"/> Other conditions | |

Date:
