Patient Information

Today's Date:_____ Name:_____

Address:_____ City: _____ State: _____ Zip:_____

Home Phone: _____ Work/Cell #: _____ Date of Birth: _____

Text Me Appt Reminders: ☐Yes ☐No E-mail:_____

Occupation: _____ Emergency Contact (Name & Phone#):_____

Are you currently under a physician's care for an acute/ chronic illness? ☐Yes ☐No

If yes please explain: _____

If yes, (Dr's Name & Address): _____

List any medications you take:_____

GENERAL & MEDICAL INFORMATION & HISTORY:

☐Yes ☐No Have you ever had a professional massage before? How often?_____

☐Yes ☐No Do you frequently suffer from stress?

☐Yes ☐No Have you ever had surgery? For what and when?_____

☐Yes ☐No Have you had a serious accident or injury in the past 2 years?
Explain:_____

☐Yes ☐No Have you broken any bones in the past two years? Where?

☐Yes ☐No Do you have any allergies? To what?

☐Yes ☐No Are you diabetic? If yes, are you insulin dependent?

☐Yes ☐No History of epilepsy or seizures? On Medications? ☐Yes ☐No. Last seizure?_____

☐Yes ☐No Do you have cardiac or circulatory problems?
- Do you use a pacemaker? ☐Yes ☐No Nitroglycerin? ☐Yes ☐No

☐Yes ☐No Do you have high blood pressure? Medications, if any:

☐Yes ☐No Do you have varicose veins? Where?

☐Yes ☐No Do you or have you had any form of blood clot, thrombus or embolism?
If Yes, Explain: _____

☐Yes ☐No Do you bruise easily? If so, are you on Coumadin or aspirin therapy?

☐Yes ☐No Are you now or trying to become pregnant? . Recently had a child?

☐Yes ☐No Currently breast feeding?

☐Yes ☐No Do you have any skin problems/conditions? Explain: _____

☐Yes ☐No Do you have or ever had any type of tumor, cancer or breast cancer?
If Yes, Explain: _____

☐Yes ☐No Have you had lymph nodes removed? Where? How many? _____

☐Yes ☐No Do you have tension or soreness in a specific area? Where? _____

☐Yes ☐No Are you sensitive to touch in any area? Where? _____

☐Yes ☐No Have you been diagnosed as having arthritis? What kind? _____

☐Yes ☐No Do you suffer from joint swelling? If yes, where? _____

☐Yes ☐No Do you have osteoporosis? Date of diagnosis? _____

☐Yes ☐No Have you seen a doctor for this problem? Name?_____

☐Yes ☐No Joint Swelling? If yes Where? _____

CURRENT COMPLAINTS / SYMPTOMS:

☐Yes ☐No Back Pain? ☐ Neck ☐ Mid-Back ☐ Lower Back

☐Yes ☐No Disc Problems? ☐ Neck ☐ Mid-Back ☐ Lower Back Specific Level(s):_____

☐Yes ☐No Radiating Pain into extremities ☐ Arms ☐ Legs

☐Yes ☐No Headaches If so, What kind?_____

☐Yes ☐No Do you have numbness or stabbing pains anywhere? Where?_____

Please list any other medical/ health conditions you suffer from or have been diagnosed with in the past: _

_____

_____

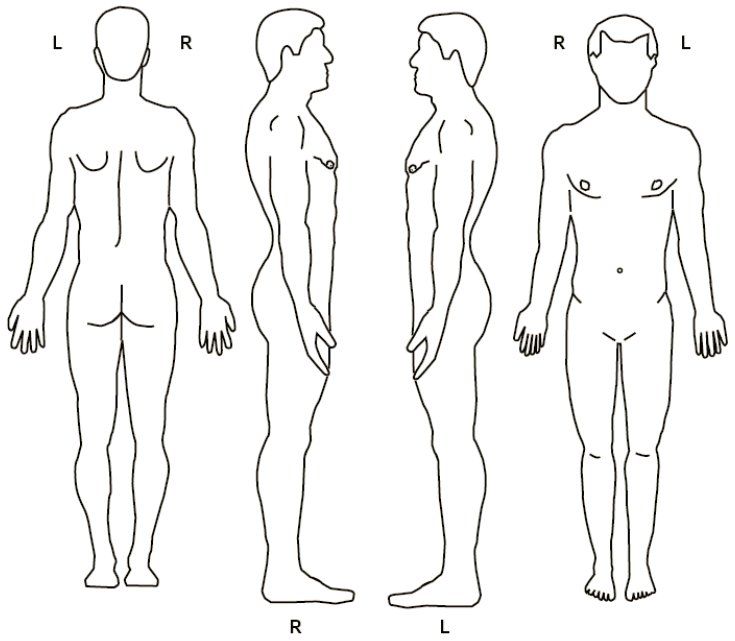
Not all aches, pains and muscular tension are caused by the daily stresses of life. Most often they are related to an underlying condition that can be treated with other non-invasive therapies available at this office. We offer free screenings and consultations to all of our Massage clients.

I would like a complimentary: ***Check all that apply***

☐ Acupuncture Consultation ☐ Chiropractic Consultation ☐ No, Thank You

P = pain or tenderness
S = joint or muscle stiffness
N = numbness or tingling

Use the letters provided in the key to identify the symptoms you are feeling today. Circle the area around each letter, representing the size and shape of each symptom location.



I have stated all conditions that I am aware of and this information is true and accurate to the best of my knowledge. I will inform my health care provider and massage therapist if anything changes in my status. I understand that massage/bodywork I receive is for the purpose of stress reduction and the relief from muscular tension, spasm or pain and to increase circulation. If I experience any pain or discomfort, I will immediately inform my massage therapist so that the pressure and/or methods can be adjusted to my comfort level. I understand that my massage therapist does not diagnose illness or disease, nor perform any spinal manipulations, and does not prescribe any medications/treatments. I acknowledge that massage is not a substitute for a medical examination or diagnosis and that I should see my health care provider for those services. If I am unable to attend my scheduled appointment, I will respect and abide by the policies of this office, including, but not limited to, cancellation fees, additional payment, office conduct..etc. I am aware it is standard practice for the therapist to ask me to disrobe to my level of personal comfort prior to the massage and I will refrain from inappropriate comments and/or propositions. I understand that I am receiving massage therapy at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy I hereby hold harmless and indemnify the therapist, their principals, and agents from all claims and liability whatsoever. In addition, I attest I have read, understand, and agree to the privacy policies of this office regarding my Personal and Protected Health Information.

Client or Guardian Signature: _____ Date: _____