Name:_____Birth date:_____

Home phone:_____Cell phone:_____

E-mail address:_____

Referred by:_____Have you had a professional massage before?_____

If so, how often?_____

Please describe your current exercise program:_____

Other daily activities:_____

Occupation:_____

Primary Care Physician:_____

Chiropractor:_____

What are the reasons for your visit today? _____

What are your other health concerns:_____

Describe any surgeries you have had:_____

Describe any accidents you have had:_____

List all conditions currently monitored by a Health Care Provider:_____

List any medications that you took today:_____

Describe, as needed, any conditions indicated above, or other conditions that you feel may be important:

_____

Please note all current and previous conditions:

Headache Y N
Stiff/painful joints Y N
Sleep Problems Y N
Neck, shoulder, or arm pain or numbness Y N
Fatigue Y N
Low back, hip or leg pain or numbness Y N
Flu or cold symptoms in the last 48 hours Y N
Sciatica Y N
Sinus Y N
Depression Y N
Allergies to scents or lotions Y N
Blood clots Y N
Allergies, in general Y N
Stroke Y N
Arthritis Y N
Heart disease Y N
Osteoporosis Y N

High/low blood pressure Y N
Scoliosis Y N
Poor circulation Y N
Broken bones Y N
Asthma Y N
Disc problems Y N
Thyroid dysfunction Y N
Spasms/cramps Y N
Diabetes Y N
TMJ (jaw pain) Y N
Currently pregnant Y N
Tendonitis/bursitis Y N
Malignant cancer or tumors Y N
Spinal Problems Y N
Benign cancer or tumors Y N
Varicose Veins Y N

Contract for care:

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my Massage Therapist and other members of my health care team. I agree to participate in the self-care program that we select. I promise to inform my health care team any time I feel my well-being is threatened or compromised. I expect my Massage Therapist to provide safe and effective treatment.

Consent for care:

It is my choice to receive massage therapy, and I give consent to receive treatment. I understand that Massage Therapists DO NOT diagnose illness, disease or any other physical or mental disorders. Massage therapy is not a substitute for medical examination and/or diagnosis. I affirm that I have stated all my known medical conditions and shall take it upon myself to keep my Massage Therapist updated on my physical/ mental health. I also agree there shall be no liability on the practitioner's part should I neglect to do so.

Signature_____Date:_____

Signature of parent/
guardian:_____Date:_____

If you are unable to keep your appointment, please give 24 hours notice.