Personal Health Information

First Name: ____ Date: ____________________

Last Name: ____ How did you hear of us? __________

Address: ____ ______________________________

City: ____

State: ____

Zip Code: ____

Phone: ____

Cell Phone: ____

Email: ____ (E-mail reminders are sent the day before your appointment)

Birth Date: ____

Occupation: ____

Emergency Contact Name :___________________________________ Phone:_________________________

MASSAGE HISTORY / TREATMENT INFORMATION

HAVE YOU EVER RECEIVED A PROFESSIONAL MASSAGE? __________YES___________NO

IF YES, FREQUENCY_________________________DATE OF LAST MASSAGE____________________

WHAT RESULTS DO YOU WANT FROM YOUR MASSAGE SESSIONS?

____

ARE THERE ANY AREAS OF YOUR BODY THAT YOU PREFER ***NOT*** TO BE MASSAGED?

____

ARE YOU CURRENTLY SEEING A MEDICAL PRACTIONER? ____________YES___________NO

IF YES, PLEASE EXPLAIN: ____

____

PLEASE LIST STRESS REDUCTION AND EXERCISE ACTIVITIES, INCLUDE FREQUENCY

____

LIST CURRENT MEDICATIONS; INCLUDE ASPIRIN, IBUPROFEN, ETC…

____

PREVIOUS HISTORY OF SURGERIES OR ACCIDENTS. INCLUDE YEAR AND TREATMENT RECEIVED

(Continued, turn page)

PLEASE INFORM US IF YOU HAVE ANY OF THE FOLLOWING;

MUSCULAR/SKELATAL

_____BONE OR JOINT DISEASE____

_____TENDONITIS____

_____BURSITIS____

_____ARTHRITIS____

_____SPRAINS/STRAINS____

_____NECK OR SHOULDERS INJURIES____

_____HEADACHES/HEAD INJURIES____

_____JOINT REPLACEMENT____

_____METAL IMPLANTS____

_____SPASMS/CRAMPS____

_____JAW PAIN/TMJ____

CIRCULATORY

_____OPEN HEART SURGERY____

_____HEART CONDITION____

_____BLOOD CLOTS____

_____PACE MAKER____

_____HIGH BLOOD PRESSURE____

_____LOW BLOOD PRESSURE____

_____LYMPHEDMA____

_____OTHER____

RESPIRATORY

_____BREATHING DIFFICULTY____

_____SINUS PROBLEMS____

_____ALLERGIES____

_____ASTHMA____

_____OTHER____

URINARY

_____PROSTATE____

_____BLADDER____

_____KIDNEY____

_____OTHER____

SKIN

____ALLERGIES____

____RASHES____

____WARTS____

___ OTHER____

DIGESTIVE

____DIVERTICULITIS____

____IRRITABLE BOWEL SYNDROME___________________________________

____OTHER____

NERVOUS SYSTEM

____FIBROMYALGIA____

____HERPES/SHINGLES____

____NUMBNESS/TINGLING____

____CHRONIC PAIN____

____FATIGUE____

____SLEEP DISORDER____

____OTHER____

REPRODUCTIVE

____PREGNANT ________________STAGE___________________________

____PMS____

____OTHER____

OTHER

___CANCER/TUMORS____

____DIABETES____

____EMPHYSEMA____

____LUPUS____

INFECTIOUS DISEASE

_____DISEASE NAME____

IT IS MY CHOICE TO RECEIVE MASSAGE THERAPY. I REALIZE THAT THE TREATMENT GIVEN IS FOR THE WELL BEING OF MY BODY & MIND. THIS INCLUDES STRESS REDUCTION RELIEF FROM MUSCULAR TENSION, SPASM, OR PAIN, OR FOR INCREASING CIRCULATION OR ENERGY FLOW. I AGREE TO COMMUNICATE WITH MY PRACTIONER ANY TIME I FEEL MY WELL BEING IS BEING COMPROMISED. I UNDERSTAND THAT MASSAGE PRACTIONERS DO NOT DIAGNOSE ILLNESS, DISEASE, OR ANY PHYSICAL OR MENTAL DISORDER. NOR DO THEY PRESCRIBE MEDICAL TREATMENT, PHARMACEUTICALS, OR PERFORM SPINAL THRUST MANIPULATIONS. I ACKNOWLEDGE THAT MASSAGE IS NOT A SUBSTITUTE FOR MEDICAL EXAMINATION OR DIAGNOSIS AND THAT IT IS RECOMMENDED THAT I SEE A PRIMARY HEALTH CARE PROVIDER FOR THAT SERVICE. I HAVE STATED ALL MEDICAL CONDITIONS THAT I AM AWARE OF AND WILL UPDATE THE MASSAGE PRACTIONERS OF ANY CHANGES IN MY HEALTH STATUS.

SIGNATUE____ DATE______________________________