First Name ________________________________ **Date of Birth** ____

Last Name ________________________________ **Referred by** ____

Email Address ________________________________ **Mobile ph #** ____

Home ph # ________________________________ **Work ph #** ____

Street Address ________________________________ **City** ____

State ________________________________ **Zip Code** ____

Emergency Contact name ________________________ **Physician's name** ____

Emergency Contact ph # ________________________ **Physician's ph #** ____

Date of Initial Visit ________________________

How would you rate your general health?

O **Excellent** O **Good**
O **Fair** O **Poor**

Have you had a professional massage before?

O **Yes (Date of last treatment)** ______________________
O **No**

List current medications and conditions

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____

List any major accidents or surgeries (include dates)

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____
____
____

List any allergies or hypersensitivities

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____
____

Reason for Initial Visit

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____

CHECK ANY AREAS OF CONCERN

Head / Neck

- O Headaches / Migraines
- O Vertigo / Dizziness
- O Ringing in ears
- O Hearing Loss
- O Vision Problems
- O Vision Loss

Respiratory

- O Asthma
- O Shortness of Breath
- O Chronic Cough
- O Bronchitis
- O Emphysema
- O Sinusitis
- O Frequent Colds
- O Smoker
- O Family History of Respiratory Difficulties

Nervous System

- O Sensory Loss / Change
- O Numbness / Tingling
- O Sciatica
- O Epilepsy
- O Seizures
- O Multiple Sclerosis

Musculoskeletal System

- O Arthritis
- O Family Hx of Arthritis
- O Osteoporosis
- O Tendonitis
- O Bursitis
- O Jaw Pain (TMJ)
- O Pins / Plates / Artificial Joints

Reproductive

- O Pregnant
- O Given Birth
- O Gynecological Problems

Cardiovascular

- O High Blood Pressure
- O Low Blood Pressure
- O Heart Attack
- O Stroke
- O Heart Disease
- O Poor Circulation
- O Phlebitis / Varicose Veins
- O Pacemaker
- O Hemophilia
- O Chronic Congestive Heart Failure
- O Family History of Cardiovascular Problems

Skin and Infections

- O Hepatitis
- O HIV / AIDS
- O Herpes
- O Tuberculosis
- O Lyme Disease
- O Infections

Other Conditions

- O Cancer
- O Diabetes
- O Unexplained Weight Loss
- O Digestive Issues
- O Fibromyalgia
- O Chronic Fatigue
- O Depression
- O Anxiety
- O Psychiatric Disorder
- O Other Conditions ___________________________

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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 of 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 and exact details of my coverage.

Signature: ____ Date: ___________________