Date _____ Birth Date _____

Name _____

Address _____

_____

Occupation: _____

Emergency Contact: _____

How did you hear about us? _____

Cell: ( ) _____-_____

Home: ( ) _____-_____

Work: ( ) _____-_____

Email: _____

Marital Status _____

Phone: _____

Accidents (what kind?)	Injury	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgeries

_____	_____
_____	_____

Existing Conditions

HEAD NECK
Tension headaches____
Migraines____
Dizziness____
Tinnitis ____
Jaw pain or dysfunction _____

SKIN & INFECTIONS
Herpes _____
Infectious skin conditions _____
Hepatitis _____ What kind? _____
HIV/AIDS _____
Tuberculosis _____
Lyme disease _____

RESPIRATORY
Asthma _____
Emphysema _____
Sinusitis _____

OTHER CONDITIONS
Cancer _____
Fibromyalgia _____
Diabetes _____ Type? _____
Digestive problems _____ Type? _____

MUSCULO-SKELETAL
Arthritis ____ where?_____
Tendinitis _____ where?
Osteoporosis _____
Bursitis _____ where? _____
Scoliosis _____

CARDIOVASCULAR
High blood pressure _____
Low blood pressure_____
Phlebitis/Varicose veins _____
Thrombosis/Embolism _____
Pacemaker _____
Heart disease _____
Stroke_____ when? _____
Lymphedema _____ where? _____

REPRODUCTIVE
Pregnant _____ due date _____
Gynecological problems _____

ADDITIONAL CONDITIONS
_____
_____
_____
_____

Present complaint: _____

If you have seen a physician, what is the diagnosis? _____

How long have you had this complaint? _____

Have you had a similar complaint before? _____ when?_____

Did the problem begin gradually? _____ suddenly? _____

What do you believe is the cause? _____

Is the problem constant? _____ intermittent?_____ If intermittent, how often? _____

Does the intensity of your problem vary?_____ Explain: _____

_____

What improves your condition? _____

What aggravates your condition? _____

Does your problem interfere with sleep? _____ work? _____ recreation?_____

How many hours do you sit? _____ stand?_____ drive? _____

What are your main activities outside of work? _____

Do you exercise regularly? _____ Describe: _____

_____

Do you believe that stress contributes to your problem? _____

If so is the stress physical? _____ emotional? _____

Have you ever been diagnosed as having a problem with your jaw (TMJD)? _____ If so, do you wear an appliance?

Are you wearing heel lifts? _____ orthotics?_____

Therapies used (including massage)	Effectiveness
_____	_____
_____	_____
_____	_____

Current Medications	Purpose	Effectiveness
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional comments:

_____

_____

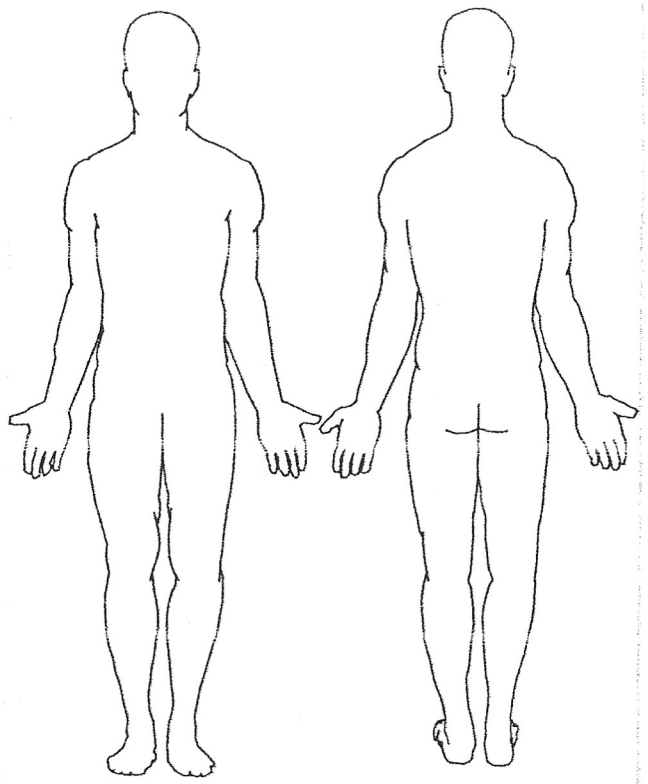
_____

_____

_____

_____

Indicate areas of discomfort on the drawings. Mark the most uncomfortable as a 1, the second most uncomfortable as a 2, etc.



Please take a moment to read and sign the following information.

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

I understand that if I do not give 24-hours notice of cancellation, I will be charged for my missed appointment, except in cases of illness or severe weather conditions. If I am not well I will cancel my appointment. The therapist will follow the same procedures for herself.

I understand that because massage therapy involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including SARS-CoV-2.

By signing this release I hereby waive and release my therapist from any and all liability, past, present, and future, relating to massage therapy and bodywork.

Signature _____ Date _____