Date __________ Birth Date __________

Cell: ( ) ________- ________

Name ________________________________________

Home: ( ) ________-__________

Address ________________________________________

Work: ( ) ________-__________

________________________________________

Email: _________________________

Occupation: ____________________________________

Marital Status ___________________

Emergency Contact: ______________________________________ Phone: _________________

How did you hear about us? ________________________________________________________

| Accidents (what kind?) | Injury | Date |
|---|---|---|
| ______________________________ | ____________________________ | __________ |
| ______________________________ | ____________________________ | __________ |
| ______________________________ | ____________________________ | __________ |

Surgeries

______________________________________________________________ __________

______________________________________________________________ __________

Existing Conditions

HEAD NECK

Tension headaches____

Migraines____

Dizziness____

Tinnitis ____

Jaw pain or dysfunction ______

MUSCULO-SKELETAL

Arthritis ____ where?_________________

Tendinitis ______ where?

Osteoporosis _______________

Bursitis _______ where? ______________

Scoliosis ______

SKIN & INFECTIONS

Herpes ______

Infectious skin conditions ___________

Hepatitis _____ What kind? __________

HIV/AIDS __________

Tuberculosis _________

Lyme disease _________

CARDIOVASCULAR

High blood pressure ______

Low blood pressure_______

Phlebitis/Varicose veins _________

Thrombosis/Embolism __________

Pacemaker ______________

Heart disease _____________

Stroke__________ when? _______

Lymphedema _______ where? _______

RESPIRATORY

Asthma _______

Emphysema ______

Sinusitis _________

REPRODUCTIVE

Pregnant ______ due date __________

Gynecological problems _____________

OTHER CONDITIONS

Cancer _______________

Fibromyalgia ______________

Diabetes ______ Type? ________

Digestive problems _______ Type? __________

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:

_____________________________________________________________________________

_____________________________________________________________________________

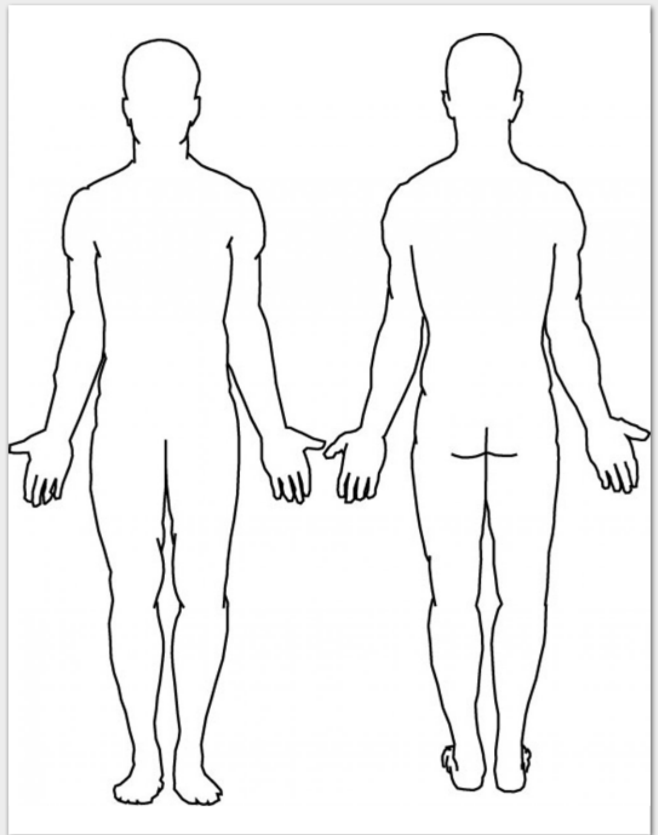
_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

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