STILLWATER DRAGON
MASSAGE THERAPY

Please fill out to the best of your ability and with as much detail as possible
If more space is needed please use margins or ask for/use additional paper

Basic Information

Name:

Phone Number:( )

Address:

Email Address:

Emergency Contact:
Name
Relationship
Phone number

Height: Date of Birth:

Frequency of massage in past (weekly, monthly, yearly, etc.):

Medical History

Are you currently under a Dr's care for any ongoing conditions? (If so please explain):

History of Injuries (past & present):

Lifetime history of surgeries:

Are you currently taking any medications and/or supplements?:

Are you currently experiencing any pain, discomfort or restriction in your body? (if so, please explain when & how it began, what you have done to try and alleviate it, what positions are more or less comfortable for you, and if it is a reoccurring issue):

Do you commonly perform any repetitive movements at home or at work? (Sitting, typing, crouching, or lifting for extended periods)

Check List

Please check any and all that apply to you, further explanation is always appreciated

Musculoskeletal:
- ☐ Bone/Joint Disease
- ☐ Tendonitis/Bursitis
- ☐ Arthritis/Gout
- ☐ Jaw Pain (TMJ)
- ☐ Lupus
- ☐ Spinal Problems
- ☐ Migraines/Headaches
- ☐ Osteoporosis

Nervous System:
- ☐ Shingles
- ☐ Numbness/Tingling
- ☐ Pinched Nerve
- ☐ Chronic Pain
- ☐ Paralysis
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease

Circulatory:
- ☐ Heart Condition
- ☐ Phlebitis/Varicose Veins
- ☐ Blood Clots
- ☐ High/Low Blood Pressure
- ☐ Lymphedema
- ☐ Thrombosis/Embolism

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Digestive:
- ☐ Irritable Bowel Syndrome
- ☐ Bladder/Kidney Ailment
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Ulcers

Respiratory:
- ☐ Breathing Difficulty/Asthma
- ☐ Emphysema
- ☐ Allergies
- ☐ Sinus Problems

Reproductive:
- ☐ Pregnant
- ☐ Ovarian/Menstrual Issue
- ☐ Prostate Issues

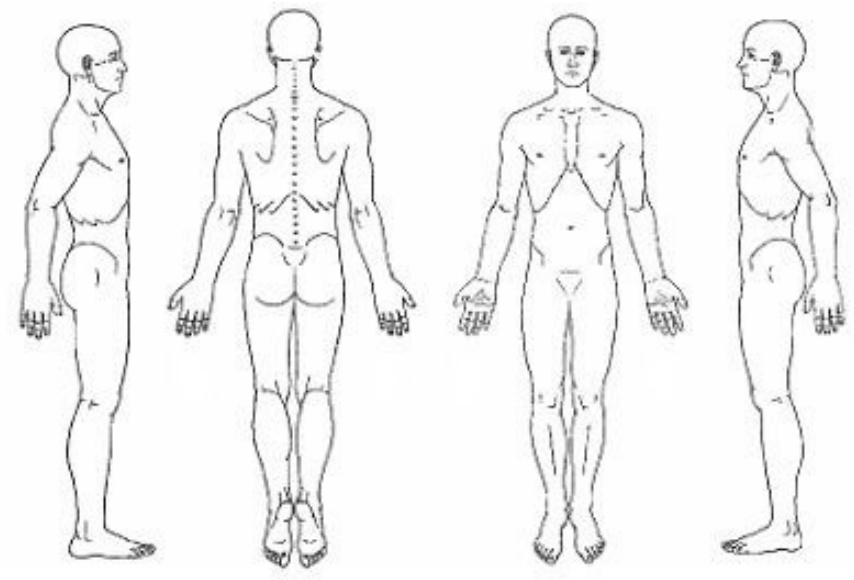
Other:
- ☐ Cancer/Tumors
- ☐ Diabetes
- ☐ Drug/Alcohol/Tobacco Use
- ☐ Contact Lenses
- ☐ Dentures
- ☐ Hearing Aids

Skin:
- ☐ Rashes
- ☐ Cosmetic Surgery
- ☐ Athlete's Foot
- ☐ Herpes/Cold Sores
- ☐ Allergies

Any other medical condition(s) not listed?:

Diagram

Please indicate on the diagram any areas of pain, discomfort, exhaustion, numbness or surgery note and label each



Client Agreement

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.

Signature: Date: