

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

Email Address \_\_\_\_\_

Home Phone # \_\_\_\_\_

Street Address \_\_\_\_\_

State \_\_\_\_\_

Emergency contact name \_\_\_\_\_

Emergency contact relationship \_\_\_\_\_

Emergency phone # \_\_\_\_\_

Date of initial visit \_\_\_\_\_

How would you rate your general health?

- Excellent
- Good
- Fair
- Poor

List current medications & the conditions they are treating

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please tell us about any allergies or hypersensitivities

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of birth \_\_\_\_\_

Referred by \_\_\_\_\_

Mobile Phone # \_\_\_\_\_

Work Phone # \_\_\_\_\_

City \_\_\_\_\_

Zip Code \_\_\_\_\_

Physician's name \_\_\_\_\_

Physician's phone # \_\_\_\_\_

Have you had a professional massage before?

- Yes (Date of last treatment) \_\_\_\_\_
- No

List any major accidents or surgeries (including dates)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for initial visit

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HEAD NECK**

- Headaches / migraines
- Ringing in ears
- Vision problems
- Vertigo / dizziness
- Hearing loss
- Vision loss

**RESPIRATORY**

- Asthma
- Chronic cough
- Emphysema
- Frequent colds
- Family history of respiratory difficulties
- Shortness of breath
- Bronchitis
- Sinusitis
- Smoker

**NERVOUS SYSTEM**

- Sensory loss / change
- Sciatica
- Seizures
- Numbness / tingling
- Epilepsy
- Multiple sclerosis

**MUSCULOSKELETAL SYSTEM**

- Arthritis
- Osteoporosis
- Bursitis
- Pins / plates / wires / artificial joint
- Family history of arthritis
- Tendonitis
- Jaw pain (TMJ)

**REPRODUCTIVE**

- Pregnant
- Gynecological problems
- Given birth

**CARDIOVASCULAR**

- High blood pressure
- Heart attack
- Heart disease
- Phlebitis / varicose veins
- Hemophilia
- Chronic congestive heart failure
- Family history of cardiovascular problems
- Low blood pressure
- Stroke
- Poor circulation
- Pacemaker

**SKIN & INFECTIONS**

- Hepatitis
- Herpes
- Lyme disease
- HIV / AIDS
- Tuberculosis
- Infectious skin conditions

**OTHER CONDITIONS**

- Cancer
- Unexplained weight loss
- Fibromyalgia
- Depression
- Psychiatric disorder
- Other conditions \_\_\_\_\_
- Diabetes
- Digestive conditions
- Chronic fatigue syndrome
- Anxiety

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 the exact details of my coverage.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_