First Name _____ Date of birth _____

Last Name _____ Referred by _____

Email Address _____ Mobile Phone # _____

Home Phone # _____ Work Phone # _____

Street Address _____ City _____

State _____ Zip Code _____

Emergency contact name _____ Physician's name _____

Emergency contact relationship _____ Physician's phone # _____

Emergency phone # _____

Date of initial visit _____

How would you rate your general health?

- ◯ Excellent
- ◯ Good
- ◯ Fair
- ◯ Poor

Have you had a professional massage before?

- ◯ Yes *(Date of last treatment)* _____
- ◯ No

List current medications & the conditions they are treating

List any major accidents or surgeries (including dates)

Please tell us about any allergies or hypersensitivities

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
- ○ Shortness of breath
- ○ Bronchitis
- ○ Sinusitis
- ○ Smoker
- ○ Family history of respiratory difficulties

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
- ○ Diabetes
- ○ Digestive conditions
- ○ Chronic fatigue syndrome
- ○ Anxiety
- ○ Other conditions _____

_____

_____

_____

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: _____