ERICA CURLESS
Licensed Massage Therapist

ERICA@ERICACURLESS.COM | WWW.ERICACURLESS.COM | (509) 991-7314

PERSONAL HEALTH INFORMATION

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (C): _____ Phone (M): _____ Email: _____

Emergency Contact: _____ Phone: _____

1. Have you had Massage Therapy before? ☐ Yes ☐ No

If you answered "Yes," what did you particularly like or dislike?

2. How would you like massage to support you?

3. Please check the areas that you like to receive massage to:

☐ back ☐ arms/hands ☐ legs/feet ☐ neck ☐ face ☐ chest ☐ buttocks ☐ abdomen

4. General Signs and Symptoms *(Check yes and add comments if you have any of the following)*:

	YES	COMMENTS
A. Are there any areas you protect?	☐	
B. Any pain or tenderness?	☐	
C. Any numbness or reduced sensation?	☐	
D. Any areas that are warm or red?	☐	
E. Any swelling or tendency to swell?	☐	
F. Fatigue?	☐	

5. Specific Medical Conditions *(Please include dates)*:

	YES	COMMENTS
A. Skin conditions	☐	
B. Allergies or sensitivities *(If you use any special lotion, feel free to bring it.)*	☐	
C. Cancer *(Please describe the type of cancer and the location)*	☐	
D. Liver or kidney conditions	☐	
E. Respiratory or lung conditions *(Such as emphysema or asthma.)*	☐	
F. Cardiovascular conditions *(History of heart condition, high blood pressure, angina, stroke, varicose veins, **blood clots.**)*	☐	
G. Diabetes *(Describe the type, any complications, whether blood sugar is well-controlled.)*	☐	
H. Bone or joint problems *(Such as osteoporosis, arthritis or bone metastasis.)*	☐	
I. Digestive problems *(Such as colitis, IBS, constipation or diarrhea.)*	☐	
J. Injuries *(Such as accidents, tendinitis, fractures.)*	☐	
K. Autoimmune *(Such as lupus, chronic fatigue syndrome or fibromyalgia.)*	☐	
L. Hematological conditions *(Such as anemia, low white blood count, low platelets.)*	☐	
M. Other	☐	

6. Surgical Procedures *(Please include approximate dates)*

Please list surgeries or surgical procedures. *If lymph nodes were tested as part of the process, please describe the area(s) from which they were removed.*

7. Medications, including chemotherapies (past and present chemos if possible). *(Please list the reason for the medication.)*

DRUG	REASON FOR TAKING	SIDE EFFECTS YOU ARE EXPERIENCING FROM THE DRUG

8. List other medical treatments, such as radiation or physical therapy. *(Please include approximate dates)*

9. Do you have any SITES to be mindful of due to *(check box):*

- ☐ incision/wound
- ☐ skin sensitivity/condition
- ☐ medical device
- ☐ radiation site
- ☐ fracture history
- ☐ area of infection
- ☐ neuropathy
- ☐ tumor site
- ☐ other

Please describe:

10. Are you experiencing any of the following *(check box):*

- ☐ history OR risk of lymphedema
- ☐ recent surgery
- ☐ infection or fever
- ☐ area of pain
- ☐ swelling
- ☐ risk of easy bruising
- ☐ pain medication
- ☐ fragile bones
- ☐ fatigue
- ☐ fragile/sensitive skin
- ☐ nausea
- ☐ other

Please describe:

11. Do you have any <u>POSITIONING</u> needs due to *(check box):*

- ☐ incision
- ☐ swelling
- ☐ medical device
- ☐ difficulty breathing
- ☐ discomfort
- ☐ tumor sites
- ☐ nausea
- ☐ other

Please describe:

12. Describe your activity level *(Tell me about your work, exercise, interests and hobbies):*

I realize that this session is being given for the purpose of relaxation and comfort. I agree to communicate with the therapist any time that I am uncomfortable or that I feel my well-being is compromised. I have listed all of the medical conditions that I am aware of.

My doctor is aware that I receive massage: ☐ Yes ☐ No

SIGNATURE DATE