MEDICAL HISTORY

Have you had a professional massage before? **Yes** **No**

If yes, how often do you receive massage therapy? _____

If yes, what type(s) of massages have you had? (i.e. Swedish, deep tissue, Thai, prenatal, etc.)

_____

What are your goals for treatment with massage therapy? What are your main health concerns for which you are seeking massage therapy? _____

_____

Do you have any difficulty lying on your stomach, back, side, or straddling a chair? **Yes** **No**

If yes, please explain _____

_____

Are/Do you wear: **Contact Lenses** **Dentures** **Hearing Aid(s)**

Do you have sensitive skin or are you sensitive to touch? **Yes** **No**

Are you allergic to massage oils, lotions, ointments, essential oils, liniments, or perfumes? **Yes** **No**

If yes, which ones/scents? _____

_____

Do you have any other allergies? **Yes** **No**

If yes, please list: _____

_____

Do you sit for long hours at a work station/desk, computer, or driving? **Yes** **No**

If yes, please describe: _____

_____

Do you perform any repetitive movement in your work, sports, or hobby? **Yes** **No**

If yes, please describe _____

_____

Do you experience stress in your work, family, or other aspect of your life? **Yes** **No**

If yes, please describe _____

_____

If yes, how do you think it has affected your health?

Muscle tension **Anxiety** **Insomnia** **Irritability** **Headaches**

Are you currently experiencing tension, stiffness, discomfort, or pain? **Yes** **No**

If yes, describe _____

_____

MEDICAL HISTORY

Are you currently under medical supervision? **Yes No**

If yes, please explain _____

_____

Are you currently taking any medication? **Yes No**

If yes, please list _____

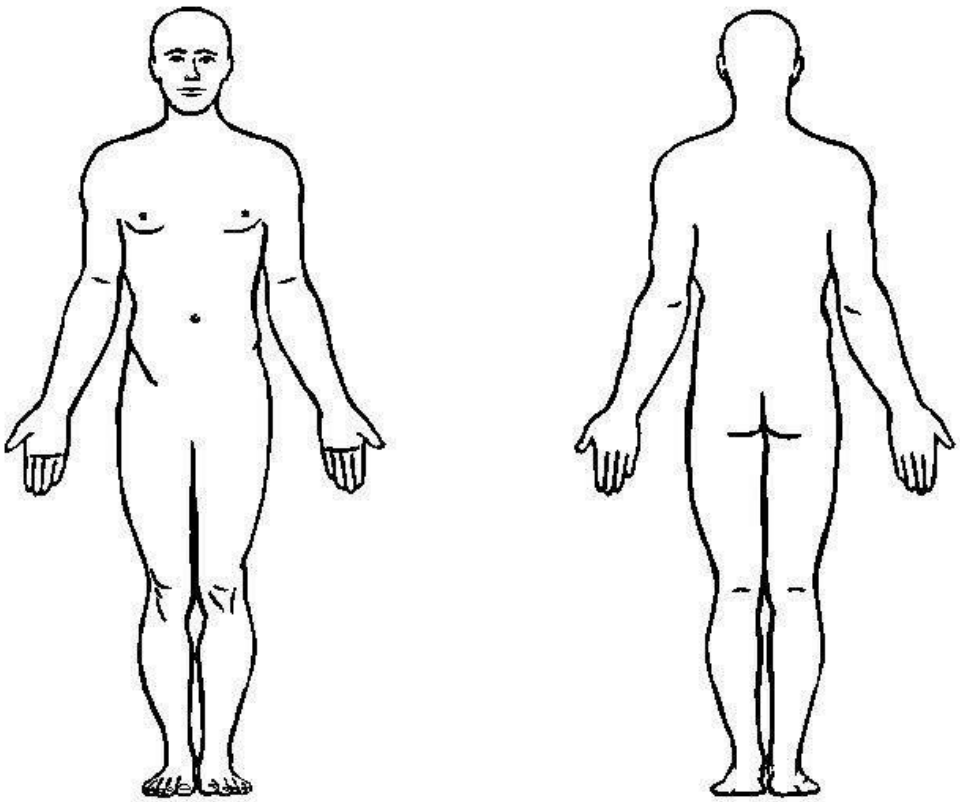
_____

Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan and provide a safe and effective massage therapy session for you?

_____

_____

Please mark any specific areas you are currently feeling pain, or would like the massage therapist to concentrate on during the session.



MEDICAL HISTORY

Do you have any of the following ***TODAY***? **Yes No**

Boils

Cellulitis

Herpes simplex/Herpes zoster/Cold Sores

Impetigo/School Sores

Lice/Mites

Sunburn/Burns

Rash

Poison Ivy/Oak/Sumac

Open Cuts or Wounds

Fungal Infection

Athletes Foot

Warts

Fever

Cold/Flu

Swollen Glands

Encephalitis

Meningitis

Polio/Post-polio Syndrome

Acute Bronchitis

Pneumonia

Sinusitis

Tuberculosis (TB)

****In First Trimester of Pregnancy**

*****Blood Clots**

******Have you had any injuries, broken bones, auto/work accidents, surgeries, or have given birth over the last 6 weeks? Yes No**

These conditions are systematically contraindicated for a massage during a flare up due to their contagious nature.

****Receiving a massage during the first trimester will induce a miscarriage. Given this knowledge, I understand that I cannot receive a massage today.

*****Blood clots can be dislodged during a massage potentially putting the patient at risk for a stroke. Given this knowledge, I understand that I cannot receive a massage today.

******Acute injuries, broken bones, auto/work accidents, surgeries, and child delivery make you high risk for blood clots and/or infections. Due to massages stimulating your blood, lymphatic, digestive, and nervous systems, a massage could cause the spread of infection and/or dislodge a blood clot. Given this knowledge, I understand that I cannot receive a massage today.

I understand that if I should have any of these conditions in the future, I need to contact my massage therapist and reschedule my massage to a date when said condition has cleared.

Signature: _____

Do you bruise easily? **Yes No**

Do you have artificial joints? **Yes No**

Do you currently have a headache? **Yes No**

Do you currently have any inflammation? **Yes No**

How would you rate your pain/discomfort today? **No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain**

MEDICAL HISTORY

Health History Check all that apply

Musculoskeletal

___ Bone or Joint Disease
___ Tendonitis/Bursitis
___ Arthritis/Gout
___ Jaw Pain (TMJ)
___ Lupus
___ Spinal Problems
___ Migraines/Headaches
___ Osteoporosis
___ Fibromyalgia
___ Myofascial Pain Syndrome
___ Myositis Ossificans
___ Shin Splints
___ Muscle spasms, cramps
___ Muscle strain, pull, sprains
___ Avascular osteonecrosis
___ Fractures
___ Paget Disease
___Postural Deviations
___ Ankylosing Spondylitis
___ Lyme Disease
___ Osteoarthritis/Rheumatoid Arthritis (RA)/Psoriatic Arthritis
___ Patellofemoral Syndrome
___ Spondylosis
___ Tennis Elbow
___ Carpal Tunnel Syndrome
___ Neck Pain
___ Mid Back Pain
___ Low Back pain
___Disc Problems/Disease
___ Decreased Range of Motion
___ Ehlers-Danlos Syndrome
__Marfan Syndrome
___Muscular Dystrophy
___Osteogenesis Imperfecta
___ Baker Cyst
___Bunions
___ Dupuytren Contracture
___ Ganglion Cysts
___ Hernia
___ Osgood-Schlatter Disease
___ Pes planus/Pes cavus
___ Plantar fasciitis
___ Scleroderma
___ Tendinopathies
___ Tenosynovitis

musculoskeletal cont.

___ Whiplash
___ Myasthenia Gravis
___ Thoracic Outlet Syndrome

Circulatory System

___ Heart Condition
___ Heart Attack
___ Heart Failure
___ Atherosclerosis
___ Phlebitis/Varicose Veins
___ Blood Clots
___ Hypertension/High Blood Pressure
___ Hypotension/Low Blood Pressure
___ Poor Circulation
___ Lymphedema
___ Thrombosis/Embolism
___ Deep Vein Thrombosis (DVT)
___ Anemia
___ Hematoma
___ Hemophilia
___ Leukemia
___ Malaria
___ Myeloma
___ Sickle Cell Disease
___ Aneurysm
___ Raynaud Syndrome
___ Varicose Veins

Respiratory System

___Breathing Difficulty/Asthma
___ Chronic Bronchitis
___ Emphysema
___ Cystic Fibrosis
___ Lung Cancer
___ Sinus Problems

Nervous System

___ Shingles
___ Numbness/Tingling
___Pinched Nerve
___ Chronic Pain
___Paralysis
___ Multiple Sclerosis (MS)
___ Parkinson's Disease
___ Nervous Tension

nervous system cont.

___ Seizures/Epilepsy
___ Alzheimer
___ Amyotrophic Lateral Sclerosis
___ Peripheral Neuropathy
___ Dystonia
___ Tremors
___ Bell Palsy
___ Cerebral Palsy
___Complex Regional Pain Syndrome
___ Spina Bifida
___ Spinal Cord Injury
___ Stroke
___ Traumatic Brain Injury
___ Trigeminal Neuralgia
___ Guillain-Barré Syndrome
___ Headaches/Migraines
___ Ménière Disease
___ Sleep Disorders/Insomnia
___ Vestibular Balance Disorders

Reproductive System

___ Pregnant, Trimester _____
___ Ovarian/Menstrual Problems
___ Prostate Cancer
___ Cervical Cancer
___ Dysmenorrhea
___Endometriosis
___ Fibroid Tumors
___ Uterine Cancer
___ Breast Cancer
___ Ovarian Cancer
___ Ovarian Cysts
___ Benign Prostatic Hypertrophy
___ Prostatitis
___ Testicular Cancer
___ Pelvic Inflammatory Disease
___ Menopause

Skin Diseases

___ Acne
___ Rosacea
___ Dermatitis, Eczema, Psoriasis
___ Hives
___ Decreased Sensation

MEDICAL HISTORY

Digestive System

___ Irritable Bowel Syndrome (IBS)
___ Bladder/Kidney Ailment
___ Ulcerative Colitis
___ Crohn's Disease
___Stomach Cancer
___ Abdominal Pain
___ Celiac Disease
___ Esophageal Cancer
___ Gastroesophageal Reflux
___ Peptic Ulcers
___ Colorectal Cancer
___ Diverticular Disease
___ Cirrhosis
___ Gallstones
___ Hepatitis
___ Liver Cancer
___ Pancreatic Cancer
___ Pancreatitis
___ Candidiasis
___ Peritonitis

Psychological Disorders

___ Anxiety/Stress Syndrome
___ Depression
___ Attention Deficit Hyperactivity Disorder (ADHD)
___ Autism Spectrum Disorder
___ Chemical Dependency
___Eating Disorder

Other

___ Acromegaly
___ Addison Disease
___ Cushing Syndrome
___ Diabetes Mellitus
___ Hyperthyroidism
___ Hypothyroidism
___ Metabolic Syndrome
___ Edema
___ Lymphangitis
___ Lymphoma
___ Mononucleosis
___ Allergic Reaction
___ Chronic Fatigue Syndrome
___ Kidney Stones
___ Pyelonephritis
___ Renal Failure
___ Bladder Cancer
___ Interstitial Cystitis
___ Urinary Tract Infection (UTI)

MEDICAL HISTORY

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage therapy may be contraindicated. A referral from your primary care provider may be required prior to services being provided.

- Draping will be used during table sessions – only the area being worked on will be uncovered.
- In some cases, therapeutic work on the gluteal muscle group (also known as *butt muscles*) is necessary.
- Informed written consent must be provided by parent or legal guardian for any client under the age of 17.
- It is the client's responsibility to notify the massage therapist if the pressure is too hard.
- I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscle tension.
- If I experience any pain or discomfort during this session, I will immediately inform the massage therapist so that the pressure and/or strokes may be adjusted to my level of comfort.
- I further understand that a massage should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician, acupuncturist, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of.
- I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said during the session given should be construed as such.
- Because a massage should not be performed under certain medical conditions, all questions need to be answered honestly.
- I agree to keep the therapist updated as to any change in m medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.
- I also understand that nay illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment and asked to never return.

Patient Signature _____ Date _____

Massage Therapist Signature _____ Date _____

Thereasa Wirkus, LMT, CEMT