One Wave Wellness

Date:

Contact Information

Name (First, MI, Last)	Date of Birth (mm/dd/yyyy)	Contact Number	Email	Referred by (if applicable)

Street Address	City	State	Zip Code

Mailing Address (if applicable)	City	State	Zip Code

Emergency Contact Information

Name (First, MI, Last)	Relationship	Contact Number

Name (First, MI, Last)	Relationship	Contact Number

Are you currently under care of a health care practitioner?	May we disclose your progress with them?

Massage and Medical History

Have you ever received a professional message?	If so, what type and how long ago?

Do you exercise regularly?	If so, how often and what type?

What immediate targets and long term goals do you have for your massage therapy treatment?

List current medications and supplements

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Name

List previous surgeries and historical medical events as well as year it occured

Please circle any of the following conditions that you may have:

Musculoskeletal	**Circulatory**
Bone or joint disease	Heart Condition
Tendonitis / Bursitis	Phlebitis / Varicose Veins
Arthritis / Gout	Blood Clots
Jaw Pain (TMJ)	High / Low Blood Pressure
Lupus	Lyphedema
Spinal Problems	Thrombosis / Embolism
Other (please specify)	Other (please specify)

Respiratory	**Skin**
Breathing Difficulty / Asthma	Rashes
Emphysema	Athletes Foot
Sinus Issues	Herpes / Cold Sores
Allergies (please specify)	Allergies (please specify)
Other (please specify)	Other (please specify)

Nervous System	**Digestive**
Shingles	Irritable Bowel Syndrome
Numbness / Tingling	Ulcers
Pinched Nerve	Other (please specify)
Other (please specify)	

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Name

Reproductive

Pregnant (stage)
Other (please specify)

Others (please elaborate)

Cancer / Tumors	Chronic Fatigue
Bladder / Kidney Issues	Chronic Pain
Substance Abuse	Sleep Disorders
Diabetes	Migraines / Headaches
Mental Health Condition(s)	Contact Lenses (hard or soft)

Other (please specify)

Initials	
	I have completed this form to the best of my knowledge and will inform the massage therapist of any change to my physical health.
	I understand that a massage therapist can not diagnose illness, disease, or any other medical, physical, emotional, or mental health disorder, nor perform any spinal manipulations. I am responsible for consulting a qualified physician for any concerns I may have.
	I understand that massage therapy is a therapeutic health aide and that the relationship between myself and the therapist shall remain strictly professional.
	I understand that if the massage therapist chooses to start the session late, the time will be added on to the end of the session if possible, or will he reduce my fee accordingly.

Print:
Signature:
Date: