PRANA Therapeutic Massage

INDIGO WELLNESS CENTER 320 Liberty St. SE, Salem, OR 97301
Diane Davidson, LMT#17602 diane@pranatherapeuticmassage.com 209.479.1800
www.indigowellnesscenter.com

HEALTH INFORMATION FORM

Client Contact Information

Client Name: _____ Date: _____
Date of Birth: _____ Gender: _____
Address: _____
Phone: _____ Email: _____
Referred by: _____
Emergency contact: _____ Phone: _____
Physician/Health-care Provider name: _____ Phone: _____
Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes ☐ No ☐
Do you have a physician referral/prescription? Yes ☐ No ☐
Are you seeking insurance reimbursement? Yes ☐ No ☐ If yes, please complete the Billing Information form.
Type of insurance coverage for this claim:
☐ Car Collision ☐ Worker's Compensation ☐ Private Health Insurance

Massage Information

Have you ever received professional massage/bodywork before? Yes ☐ No ☐
How recently? _____
What types of massage/bodywork do you prefer? _____
What kind of pressure do you prefer? Light Medium Firm
What are your goals/expected outcomes for receiving massage/bodywork?
_____
_____

How do you feel today? _____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):
_____
_____

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No
Explain:
_____
_____

List the medications you currently take:
_____
_____

Are you wearing contacts? Yes ☐ No ☐
Are you wearing dentures? Yes ☐ No ☐
Are you wearing a hairpiece? Yes ☐ No ☐
Are you pregnant? Yes ☐ No ☐

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Health History

Have you had any injuries or surgeries in the past that may influence today's treatment?

_____

Circle any of the following health conditions that you currently have (If you are unsure, please ask):
blood clots, infections, congestive heart failure, contagious diseases, pitted edema
Please answer honestly, as massage may not be indicated for the above conditions.

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

Current	Past	Muscle or joint pain _____
Current	Past	Muscle or joint stiffness _____
Current	Past	Numbness or tingling _____
Current	Past	Swelling _____
Current	Past	Bruise easily _____
Current	Past	Sensitive to touch/pressure _____
Current	Past	High/Low blood pressure _____
Current	Past	Stroke, heart attack _____
Current	Past	Varicose veins _____
Current	Past	Shortness of breath, asthma _____
Current	Past	Cancer _____
Current	Past	Neurological (e.g. MS, Parkinson's, chronic pain) _____
Current	Past	Epilepsy, seizures _____
Current	Past	Headaches, Migraines _____
Current	Past	Dizziness, ringing in the ears _____
Current	Past	Digestive conditions (e.g. Crohn's, IBS) _____
Current	Past	Gas, bloating, constipation _____
Current	Past	Kidney disease, infection _____
Current	Past	Arthritis (rheumatoid, osteoarthritis) _____
Current	Past	Osteoporosis, degenerative spine/disk _____
Current	Past	Scoliosis _____
Current	Past	Broken bones _____
Current	Past	Allergies _____
Current	Past	Diabetes _____
Current	Past	Endocrine/thyroid conditions _____
Current	Past	Depression, anxiety _____
Current	Past	Memory Loss, confusion, easily overwhelmed _____

Comments:

_____

_____

Client Name: _____ Date: _____

Client Signature: _____

Parent or Guardian (in case of a minor)