First Name _____

Last Name _____

Email Address _____

Home Phone # _____

Street Address _____

State _____

Emergency contact name _____

Emergency contact relationship _____

Emergency phone # _____

Date of initial visit _____

Date of birth _____

Referred by _____

Mobile Phone # _____

Work Phone # _____

City _____

Zip Code _____

Physician's name _____

Physician's phone # _____

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

_____

_____

_____

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. I further acknowledge that it is my responsibility to confirm with my health care provider the details of my coverage and specific number of covered visits are applicable to my treatment. I am responsible to confirm the availability of coverage before each visit. I acknowledge that, if coverage is denied, for any reason, including, but not limited to exceeding my allotted visit amount, I am fully responsible for any fees and expenses associated with that visit, and I will be billed accordingly.

Signature: _____ Date: _____