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
- ◯ Vertigo / dizziness
- ◯ Ringing in ears
- ◯ Hearing loss
- ◯ Vision problems
- ◯ Vision loss

### RESPIRATORY

- ◯ Asthma
- ◯ Shortness of breath
- ◯ Chronic cough
- ◯ Bronchitis
- ◯ Emphysema
- ◯ Sinusitis
- ◯ Frequent colds
- ◯ Smoker
- ◯ Family history of respiratory difficulties

### NERVOUS SYSTEM

- ◯ Sensory loss / change
- ◯ Numbness / tingling
- ◯ Sciatica
- ◯ Epilepsy
- ◯ Seizures
- ◯ Multiple sclerosis

### MUSCULOSKELETAL SYSTEM

- ◯ Arthritis
- ◯ Family history of arthritis
- ◯ Osteoporosis
- ◯ Tendonitis
- ◯ Bursitis
- ◯ Jaw pain (TMJ)
- ◯ Pins / plates / wires / artificial joint

### REPRODUCTIVE

- ◯ Pregnant
- ◯ Given birth
- ◯ Gynecological problems

### CARDIOVASCULAR

- ◯ High blood pressure
- ◯ Low blood pressure
- ◯ Heart attack
- ◯ Stroke
- ◯ Heart disease
- ◯ Poor circulation
- ◯ Phlebitis / varicose veins
- ◯ Pacemaker
- ◯ Hemophilia
- ◯ Chronic congestive heart failure
- ◯ Family history of cardiovascular problems

### SKIN & INFECTIONS

- ◯ Hepatitis
- ◯ HIV / AIDS
- ◯ Herpes
- ◯ Tuberculosis
- ◯ Lyme disease
- ◯ Infectious skin conditions

### OTHER CONDITIONS

- ◯ Cancer
- ◯ Diabetes
- ◯ Unexplained weight loss
- ◯ Digestive conditions
- ◯ Fibromyalgia
- ◯ Chronic fatigue syndrome
- ◯ Depression
- ◯ Anxiety
- ◯ Psychiatric disorder
- ◯ Other conditions _____

_____

_____

_____

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.

Signature: _____ Date: _____