Name____

Today's Date____________________ Date of Birth____________________

Address____

City ____________________ State__________ Zip Code__________

May we mail information to the above listed address? Y N

Phone: Where would you like us to call you? List all that apply.

Home:______________ Work:______________ Mobile:______________

Email address:____

Who should be contacted in case of an emergency?

Name____________________ Relationship______________ Phone______________

Name____________________ Relationship______________ Phone______________

If you would like us to send reports or coordinate care with another health care provider,
please list the contact information below.

Name______________________________ Phone:______________

Do you carry an EpiPen in case of anaphylaxis? Y N

If yes, where do you keep it?____

Who may we thank for referring you to us? ______________________________

CONFIDENTIAL HEALTH INFORMATION

NAME: ________________________

Informed Consent

I understand that I am an active participant in my wellness. It is my choice to receive care from a massage therapist. I agree to communicate with my practitioner at any time that I feel uncomfortable, or any time that I feel that my well-being is being compromised in any way. I agree to communicate with my practitioner if I experience any discomfort during or following a session. I understand that I will be kept draped at all times. I understand that my breasts and genitals will not be exposed or massaged. I understand that I may request that the massage session end at any time.

I understand that massage practitioners do not diagnose illness, disease or any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have had an opportunity to ask questions regarding care modalities and the qualifications of my practitioner. I have had opportunity to discuss my practitioner's policies regarding clients. I have stated all medical conditions that I am aware of, and will update the massage practitioner of any changes in my health status.

Client Signature:____ Date:____________________________

Therapist Signature:____ Date:____________________________

The consent below allows you to include or exclude areas of the body for treatment. At each session you and your practitioner will determine a plan for the session and you may choose to limit work on certain areas for that day, even if consent is given below.

Consent for Specific Bodywork (Initial for consent)

_______ Back
_______ Legs
_______ Hips and gluteal muscles
_______ Arms
_______ Abdomen
_______ Chest (Excludes breast tissue)
_______ Neck
_______ Face
_______ Head
_______ Other (Specify) _______________

NAME: ______________________

Allergies: Please list all allergies and known reactions in the space below. Please include any allergies to medication, herbs, plants, supplements, environmental allergies, and food allergies.

____

____

____

Medications: Please list any medications (prescription and over the counter) that you are presently taking.

____

____

____

Hospitalizations, Falls, Accidents, or Other Injuries: Please list the type of trauma and the date.

____

____

____

Where in your body do you experience stress?

____

____

____

List your type of work and hobbies, including sports, exercise, and most common activities:

____

____

____

NAME: ______________________

History of symptoms and conditions.

This list is divided into systems of the body. At the top of each section, there is a question regarding that body system. If you don't have any issues in this area, please indicate that in this initial question, and then continue to the next body system. If you have a history of problems in that body section, please evaluate the list that follows to specifically identify your exact condition.

MUSCULAR / SKELETAL

Do you have a history of symptoms or conditions in these body systems? Y N If yes, please indicate below.

- O Bone or joint disease
- O Tendonitis
- O Bursitis
- O Broken/fractured bones
- O Arthritis
- O Osteopenia
- O Sprains/ strains
- O Low back, hip, leg pain
- O Falls
- O Neck, shoulder, arm pain
- O Headaches / head injuries
- O Fibromyalgia
- O Spasms / cramps
- O Jaw / TMJ pain, popping, clicking, burning
- O Lupus
- O Osteoporosis
- O Degenerative Disc Disease
- O Scoliosis
- O Ankylosing spondylitis
- O Spondylosis
- O Other:_______________

CIRCULATORY / RESPIRATORY

Do you have a history of symptoms or conditions in these body systems? Y N If yes, please indicate below.

- O Heart condition
- O Varicose veins
- O High blood pressure
- O Low blood pressure
- O Lymph edema
- O Breathing difficulty
- O Anemia
- O Sinus problems
- O Allergies
- O Swelling in ankles
- O Irregular heartbeat
- O Bleed or bruise easily
- O Blood clots
- O Asthma
- O Scleroderma
- O Sleep Apnea

DIGESTIVE

Do you have a history of symptoms or conditions in this body system? Y N If yes, please indicate below.

- O Constipation
- O Diverticulitis
- O Acid Reflux
- O Other:_______________

SKIN

Do you have a history of symptoms or conditions in this body system? Y N If yes, please indicate below.

- O Allergies
- O Rashes
- O Athletes foot
- O Bruises
- O Warts
- O Sores
- O Scars
- O Excema
- O Other:_______________

NERVOUS SYSTEM

Do you have a history of symptoms or conditions in this body system? Y N If yes, please indicate below.

- O Numbness / tingling
- O Chronic pain
- O Fatigue
- O Sleep disorders
- O Anxiety
- O Seizures
- O Neuromuscular diseases
- O Other:_______________

REPRODUCTIVE SYSTEM

Do you have a history of symptoms or conditions in this body system? Y N If yes, please indicate below.

- O Pregnant
- O Menopause
- O PMS
- O Prostate problems
- O Endimetriosis
- O Adenomyosis
- O Other:_______________

OTHER

- O Cancer / tumors
- O Diabetes Type 1
- O Diabetes Type 2
- O Eating disorders
- O Depression
- O Liver Disease
- O Dizziness
- O Ringing in ears
- O Kidney Disease
- O Change in weight during last 6
- O Hyperthyroidism/Hypothyroic
- O Drug / alcohol addiction