Name _____ Date _____ Date of Birth _____
Phone-Work _____ Home _____ E-mail _____
Address _____ City _____ State _____ Zip _____
Occupation _____ Employer _____
Work Responsibilities _____
Primary Care Provider _____ Phone _____ Fax _____
Address _____ City _____ State _____ Zip _____
Emergency Contact _____ Relationship _____
Phone-Work _____ Home _____ Cell/Pager _____

## Current Health

Have you ever received massage therapy before? __ Yes __ No Frequency: _____
Reason for today's visit: _____
Desired results of today's session: _____
Today's primary concern or goal: _____ Other: _____
Classify concern: __ Minor __ Problematic __ Major
Classify type: __ Recurring __ Getting worse __ Getting better
Have you had this concern/goal before? __ Yes __ No Explain: _____
Have you received treatment for this before? __ Yes __ No Explain: _____
List activities affected: _____
Current medications: _____
(include over-the-counter pain relievers and herbal remedies)
Stress reduction/exercise activities: _____ Frequency: _____

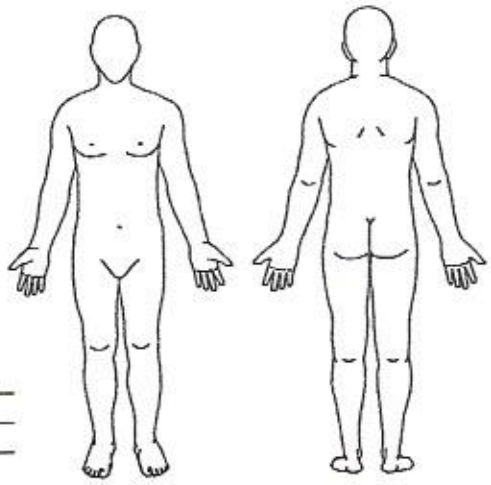
Check any of the following that apply to your current health:

__ pregnancy __ heart conditions __ circulatory conditions __ blood clots __ diabetes
__ infections __ cancer __ difficulty breathing __ arthritis

Comments: _____
Is there anything I should know to ensure your comfort regarding: _____
Allergies/sensitivities: __ oils __ lotions __ scents __ detergents __ foods __ animals __ other: _____
Contact lenses (the face pillow may put pressure on your eyes): _____
Hearing abilities (communication is helpful during the session): _____
Hair, make-up, clothes (Will you return to work after your session?): _____
Movement abilities (i.e., getting on and off the table, pillows, etc.): _____
Comments: _____

## Mark on figures all areas of:

Pain, tenderness with O's
Numbness, tingling with ZZ's
Swelling, stiffness with X's
Scars, bruises, open wounds with HH's



## Rate severity of all symptom areas from 1-10:

(1 = I feel like a newborn baby, 10 = Put me out of my misery)

1 2 3 4 5 6 7 8 9 10

## Previous History

(list in chronological order, give dates or ages, and treatment received)

Surgeries: _____
Accidents: _____
Major illnesses: _____

## Consent for Care

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 or 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.

Signature _____ Date _____