

Confidential Patient History

Today's Date _____

Name _____ Address _____

Phone number: ((h) _____ (c) _____ (w) _____

Occupation: _____ Email Address: _____

Referred by: _____ May we contact you via email? Yes No

General Medical History

Please put a check by all conditions that you have had (past or present) and list the date of diagnosis

- | | | |
|---|---|--|
| <input type="checkbox"/> allergies | <input type="checkbox"/> circulatory issue | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> arthritis - osteo | <input type="checkbox"/> depression | <input type="checkbox"/> other** |
| <input type="checkbox"/> arthritis - rheumatoid | <input type="checkbox"/> diabetes | <input type="checkbox"/> sciatica |
| <input type="checkbox"/> asthma | <input type="checkbox"/> digestive problems | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> athlete's foot | <input type="checkbox"/> dislocations | <input type="checkbox"/> seizures |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> dizziness | <input type="checkbox"/> sinusitis |
| <input type="checkbox"/> blood pressure | <input type="checkbox"/> headaches/migraines | <input type="checkbox"/> sprains/strains |
| <input type="checkbox"/> high (or) low | <input type="checkbox"/> head injuries | <input type="checkbox"/> stress |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> heart problems | |
| <input type="checkbox"/> herpes virus or shingles | <input type="checkbox"/> tendonitis | |
| <input type="checkbox"/> bursitis | <input type="checkbox"/> infectious disease | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> cancer | <input type="checkbox"/> jaw pain/TMJ | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> chronic pain | <input type="checkbox"/> kidney problems | <input type="checkbox"/> vision problems |
| <input type="checkbox"/> contagious (ex. Cold or Flu) | <input type="checkbox"/> muscle or joint pain | <input type="checkbox"/> warts |
| <input type="checkbox"/> skin conditions | <input type="checkbox"/> numbness/tingling | <input type="checkbox"/> whiplash |

** Other (please describe) _____

Do you have any allergies? If yes, what are you allergic to?: (examples: laytex, nuts, dust, mold, fragrance etc)

List All Prescription Medications You Are Currently Taking (includes aspirin, ibuprofen, herbs, supplements etc):

NAME OF MEDICATION

WHY DO YOU TAKE THIS?

Are you taking any form of narcotic/pain modifying medication(s) (this would include alcohol) ? Yes No
If so, how often do you take it? _____ Did you take any today? _____

Any recent hospitalizations (this includes emergency room visits)? _____
if so why? _____

Any recent falls, accidents, injuries, sprains or the like within that past 48 hours? Yes No
If so, what happened? _____

Please list ALL past surgeries/hospitalizations/illnesses/accidents:

TYPE of SURGERY/HOSPITALIZATIONS/ACCIDENTS & DATES	REASON FOR SURGERY/HOSPITALIZATION/ACCIDENT
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have a pacemaker, implants, defibrillator, pins, fusion of vertebrae, or any other metal/medical devices?
Yes No

If yes, what type? _____

Are you or could you be Pregnant? _____ If so, How many weeks? _____

Please list all forms and frequency of stress reduction activities, hobbies, exercise or sports participation:

MASSAGE:

What is the reason for today's visit? _____

Please describe your major complaint: _____

How did it happen: _____

Date started: _____

Please describe: _____

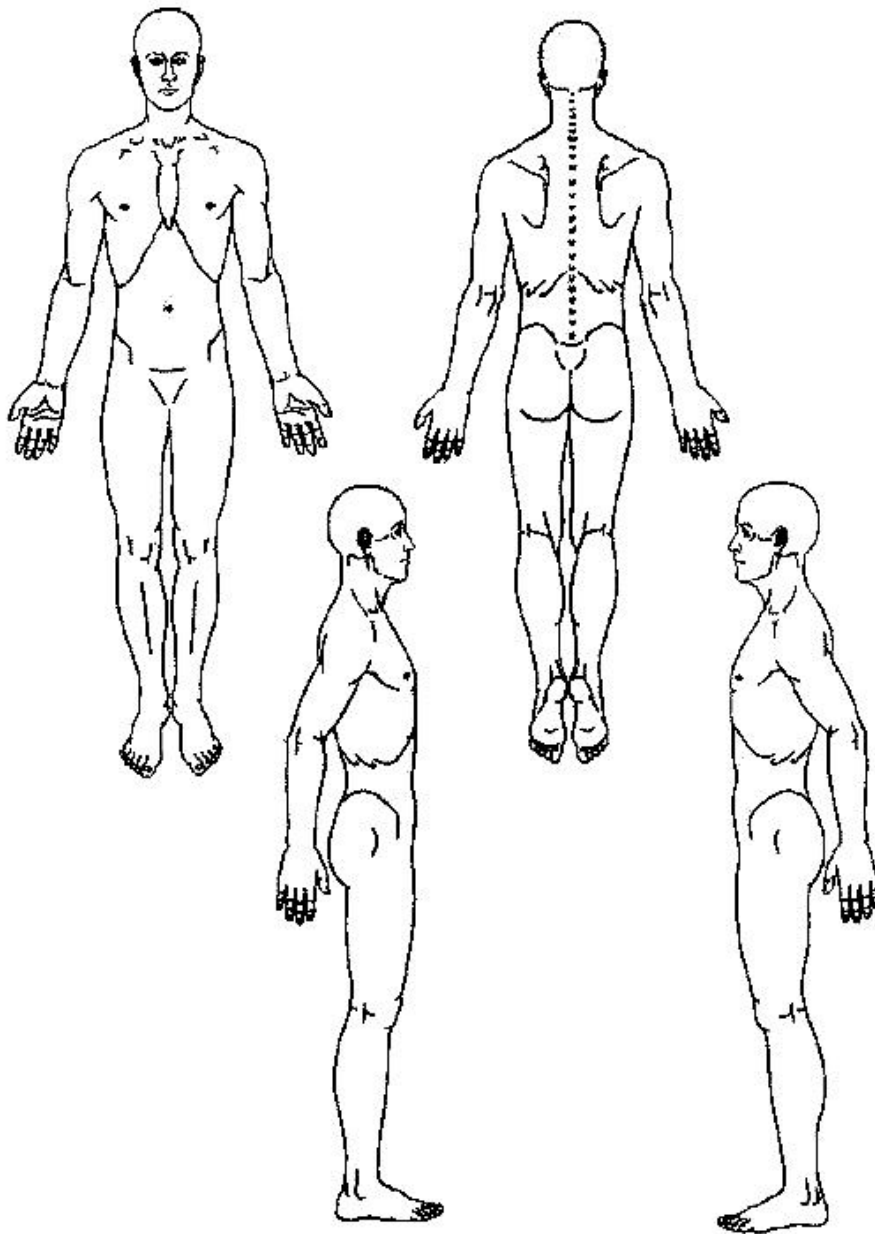
Is this interfering with (please circle): Work Sleep Daily Routine Sports Recreation Other

Please explain further: _____

What is your goal ? _____

What is your preference: Pressure (please circle one of the following): Light Moderate Deep

Are you seeking relaxation or therapeutic massage treatment? _____



Rate severity of your discomfort on a scale of 1-10 (Please circle)

Pain Scale: minor - 1 2 3 4 5 6 7 8 9 10 severe-10

I, _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

CLIENT SIGNATURE: _____ DATE _____

THERAPIST SIGNATURE: _____ DATE: _____