

CONFIDENTIAL INFORMATION

Welcome! We want to make your appointment as pleasant and comfortable as possible.
If at any time you have questions regarding your therapy session, please let us know.

NAME: _____ HOME NO.: _____ WORK NO.: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ E-MAIL ADDRESS: _____

OCCUPATION: _____ REFERRED BY: _____

HAVE YOU EVER RECEIVED MASSAGE THERAPY? YES NO

TYPE OF MASSAGE EXPERIENCED: DEEP TISSUE SWEDISH OTHER

ARE YOU TAKING MEDICATION? _____ DESCRIBE _____

ARE YOU PREGNANT? _____

HAVE YOU CONSUMED ALCOHOL IN THE PAST 24 HOURS? YES NO

DO YOU HAVE A HISTORY OF THE FOLLOWING?:

- | | | |
|--|---|--|
| <input type="checkbox"/> neck pain | <input type="checkbox"/> sprains | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> whiplash | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> stroke |
| <input type="checkbox"/> headaches | <input type="checkbox"/> wear contacts | <input type="checkbox"/> heart attach |
| <input type="checkbox"/> shoulder pain | <input type="checkbox"/> scoliosis | <input type="checkbox"/> cancer |
| <input type="checkbox"/> upper back pain | <input type="checkbox"/> surgery | <input type="checkbox"/> colitis |
| <input type="checkbox"/> mid back pain | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> HIV |
| <input type="checkbox"/> low back pain | <input type="checkbox"/> carpal tunnel syndrome | <input type="checkbox"/> _____ |
| <input type="checkbox"/> joint ache | <input type="checkbox"/> mastectomy | <input type="checkbox"/> _____ |
| <input type="checkbox"/> decreased range of motion | <input type="checkbox"/> hepatitis | |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> diabetes | |
| <input type="checkbox"/> sciatica | <input type="checkbox"/> varicose veins | |
| | <input type="checkbox"/> high blood pressure | |

| Please indicate your consumption level: | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| | None | Light | Moderate | Heavy |
| salt | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| sugar | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| caffeine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| tobacco | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| water | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

DO YOU HAVE ANY OF THE FOLLOWING TODAY?:

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> sunburn | <input type="checkbox"/> open cuts, bruises, burns |
| <input type="checkbox"/> inflammation | <input type="checkbox"/> irritated skin rash |
| <input type="checkbox"/> sever pain | <input type="checkbox"/> poison ivy |
| <input type="checkbox"/> headache | <input type="checkbox"/> cold/flu |

WHAT ARE YOUR GOALS/EXPECTATIONS FOR THIS THERAPY SESSION? _____

PLEASE READ THE FOLLOWING & SIGN BELOW

- I understand that this massage is not a replacement for medical care and that no diagnosis will be made.
- I am responsible for paying for any appointment cancellation of less than 24 HOURS.

DATE: _____ SIGNATURE: _____

PLEASE INDICATE WITH AN (X), THE AREAS YOU ARE FEELING DISCOMFORT

