SANCTUS

1372 Old Bridge Road – Suite 102 – Woodbridge, VA 22192

www.MassagesatSanctus.com

Section l: Client Information **Date:_____**

Name: _____ I Prefer to be called: _____
Address: _____ City: _____ State: ____ Zip _____
Phone (__)_____ Work Phone (__)_____ Cell Phone (__)_____
The best time to contact me is: _____ [ ] AM [ ] PM on my [ ] Home phone [ ] Work Phone [ ] Cell phone
Date of Birth _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____
Email Address _____ Would you like to receive our e-newsletter? [ ] Yes [ ] No

Lifestyle & Occupation

Please circle the answer closest to how you presently feel (1 = poor, 5= excellent)

Quality of sleep	1	2	3	4	5
Energy level	1	2	3	4	5
Exercise habits	1	2	3	4	5
Fluid intake	1	2	3	4	5

Current Stress Level: [ ] Constant [ ] Moderate [ ] Mild [ ] None

Do you experience high levels of stress? [ ] Yes [ ] No If yes, do you think stress has affected your health? [ ] Yes [ ] No If yes, indicate how: [ ] Muscle tension [ ] Anxiety
[ ] Insomnia [ ] Irritability [ ] Other (list) _____

Please circle you're average number hours of sleep per night 8+ 7 6 5 4 3 or less
Do you wake during the night? [ ] Yes [ ] No
Do you feel rested in the morning? [ ] Yes [ ] No
Are you often tired in the afternoon? [ ] Yes [ ] No

Do you exercise [ ] Yes [ ] No If yes, how often? _____
Type of exercise _____ Other Activities _____

Occupation: _____
How many hours do you work per week on average? _____
How do you spend most of your work day? _____
[ ] Sitting [ ] Sitting w/mostly computer work [ ] Standing
[ ] Light manual labor [ ] Manual Labor [ ] Hard Manual Labor [ ] Homemaker

Do you perform repetitive movement in your work, sport or hobby? [ ] Yes [ ] No
If yes, describe _____
_____

Current Health

Are you currently under a physician's care for an acute or chronic illness? [ ] Yes [ ] No
If yes, please explain _____
_____Who is your health care provider? _____
Are you currently taking any prescribed medication or dietary supplements? [ ] Yes [ ] No

Please check those you are currently taking:
[ ] Blood pressure meds [ ] Aspirin/Anti-inflammatory [ ] muscle relaxants [ ] Pain killers [ ] Blood thinner [ ] Anti-anxiety/depressants [ ] Sleeping pills [ ] Cortisone injection(s) Other Medications
_____
_____
Allergies/hypersensitivity to what? _____
Type of reaction: _____
Are you allergic to any oils, lotions, or ointments? [ ] Yes [ ] No If yes, please list them
_____
_____

Check if Yes: Do you wear [ ] Contacts [ ] Dentures [ ] Hearing Aid [ ] Pacemaker

What kind of diagnostic procedures are you undergoing/have undergone? (Ex: MRI, Blood Test, X-Ray)
_____

Are you Pregnant? [ ] Yes [ ] No If yes, due date _____

Do you experience difficulty lying on your stomach, back of other part of your body? [ ] Yes [ ] No

Did a health care practitioner refer you for massage therapy? [ ] Yes [ ] No

Have you ever received a professional massage? [ ] Yes [ ] No Date of last massage_____
What result do you want from your massage sessions? _____
_____
Do you have any goals in mind for today's session related to any of the conditions mentioned?
_____
Where are you currently feeling pain or tension? _____
Do you have limited range of motion? Where? _____
Any other medical condition your massage practitioner should know about? _____

Please use the letters provide in the key to identify the symptoms you are feeling today. Circle the area that is affected on each image with the appropriate letter/symptom written inside the circle).

P = pain or tenderness S = joint or muscle stiffness B = numbness or tingling

How long have you suffered with this discomfort? _____

Pain Assessment (if applicable): On a scale from 0 – 10, 10 being the worst, please rate your pain.

Current Pain	0	1	2	3	4	5	6	7	8	9	10
Worst Pain	0	1	2	3	4	5	6	7	8	9	10
Least Pain	0	1	2	3	4	5	6	7	8	9	10

Previous History (Include year and treatment received)

Please describe any injuries or surgeries in the past 5 years

Surgery: _____ Surgery Date: _____

Nature: _____

Surgery: _____ Surgery Date: _____

Nature: _____

Surgery: _____ Surgery Date: _____

Nature: _____ Surgery Date: _____

Surgery: _____ Surgery Date: _____

Nature: _____

Injuries/accidents/illnesses still affecting you:

Injury – Date: _____ Injury – Date: _____

Nature: _____ Nature: _____

Injury – Date: _____ Nature: _____

Nature: _____ Nature: _____

General Signs and Symptoms	***No***	***Yes***	***Where***
Any swelling or tendency to swell?			
Any sites of pain/tenderness?			
Any sites of numbness?			
Any sites of infection?			
Any sites of open wounds			
Any sunburn sites			

Health History

Please indicate any conditions you have experienced. If it is current condition, check first box (C) If it is a past condition, check second box (P). You may check both current (C) and (P) for a condition

Musculoskeletal			**Skin**			**Neurology/Eyes/Head**		
Current	Past		Current	Past		Current	Past	
		Bursitis			Unexplained rash			Contacts
		Rheumatoid Arthritis			Contagious Skin Condition			Dizziness/Fainting
		Arthritis/Gout			Eczema			Epilepsy/Other Seizures
		Osteoarthritis			Serious Burn			Head Injury
		Osteoporosis			Pressure Ulcer			Headaches/Migraines
		Compression Syndrome			Psoriasis			MJ/Jaw Pain
		Degenerative Disc			Other Skin Condition			Spinal Cord Injury
		Joint Disease			Athletes Foot			Glaucoma
		Ligaments/Joint Sprain			Herpes			Lupus
		Muscle Strain/Spasm			Cold Sores			Chronic Pain/Fibromyalgia
		Scoliosis						Chronic Fatigue Syndrome
		Postural Abnormalities	**Urinary System**					Muscular Dystrophy
		Implants			Incontinence			Peripheral Neuropathy
		Wires/artificial joints or special equipment			Kidney Disease			
		Rods/Pins/Plates/ Shunts			Urinary Tract Infections	**Reproduction**		
		Tendonitis			Prostate			Pregnant
		Transplants						Infertility
		Sciatica	**Mental Health**					PMS/Irregular Periods
		Broken Bone			Therapy/Counseling			Menopausal Symptoms
		Spinal Injury			Eating Disorder			Mood Swings
					Addiction to drugs/alcohol			
Respiratory System					Suicidal thoughts	**Circulatory System**		
		Asthma			Depression/Anxiety			Heart Disease
		Bronchitis/ Pneumonia			P.T.S.D.			High / Low BP
		Emphysema						Varicose Veins
		Sinusitis	**Immune System**					Blood Clots
		Tuberculosis			Current Cold/ Flu/ Virus			Stomach Condition
					Current Fever			Diabetes Type I, II
Digestive					Allergic Reactions			Lymphedema
		Constipation			Autoimmune Disease			Hypoglycemia
		Diarrhea			HIV/AIDS			Stroke
		Hernia			Cancer/Tumors			
		Irritable Bowel/Colitis			Thyroid			
		Gastritis/Ulcer			Hypo/Hyper-thyroidism			

Other Health Conditions: