

Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
Address \_\_\_\_\_ City, ZIP \_\_\_\_\_  
Phone Daytime \_\_\_\_\_ Home \_\_\_\_\_ Cell \_\_\_\_\_  
Birth Date \_\_\_\_\_ Martial Status:  Married  Single  Divorced  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Referred By \_\_\_\_\_

Insurance?:  No  Yes Insurance Name \_\_\_\_\_  
Policy Number \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Phone \_\_\_\_\_  
Physician: Name \_\_\_\_\_ Phone \_\_\_\_\_

**Message Information**

First professional massage:  Yes  No; how frequently do you have massage: \_\_\_\_\_

**Medical Information**

List accidents/injuries, hospitalizations, and surgeries: when they occurred and treatment received  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any lingering effects from the above or do you feel you have recovered?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Chronic, ongoing pain?  No  Yes, please describe and any care or treatment you receive  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do activities affect the pain?  No  Yes, please describe  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently being treated medically or taking prescribed drugs?  No  Yes, please describe  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all over the counter, supplements, and/or herbs taken and why

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**History** (helps determine treatment options)

**Musculoskeletal**

- Osteoporosis
- Arthritis
- Hypothyroidism
- Fibromyalgia
- Chronic Fatigue
- Gout in \_\_\_\_\_
- Bursitis
- Plantar Fasciitis
- Cysts/Lipomas
- TMJ
- Chronic Headaches
- Tendonitis
- Whiplash
- Strains/Sprains
- Chronic pain in:
  - Neck
  - Low-back
  - Mid-back
  - Upper-back
  - Hip
  - Arm
  - Leg
  - Shoulder
  - Wrist/Hand
- On computer more than 2 hrs/day. No. of hrs: \_\_\_\_\_

**Respiratory**

- Pneumonia
- Asthma
- Breathing Problems
- Sinusitis
- Other: \_\_\_\_\_

**Digestive**

- Ulcers
- Colitis
- IBS
- Crone's disease
- Gluten Intolerance
- Constipation
- Diarrhea
- Gallstones
- Gas/Bloating
- Chronic Indigestion

**Circulatory**

- Heart problems: \_\_\_\_\_
- Stroke
- Palpitations
- Mitral valve prolapse
- Anemia
- Hemophilia
- Hypertension
- Low Blood Pressure
- Peripheral Artery Disease
- Raynaud's Disease
- Varicose veins
- Blood clots/Phlebitis

**Skin**

- Fungal infections
- Athlete's Foot
- Impetigo
- Eczema/Dermatitis
- Psoriasis
- Easily irritated skin
- Other: \_\_\_\_\_

**Nervous System**

- Dizziness
- ALS
- Multiple Sclerosis
- Parkinson's disease
- Bell's Palsy
- Neuritis
- Spinal cord injury
- Trigeminal Neuralgia
- Seizures/Epilepsy

**Other**

- Diabetes
- Pregnancy
- Cancer
- Kidney disease
- Hepatitis
- HIV/AIDS
- Lupus
- Postoperative: \_\_\_\_\_
- Cystitis
- High stress
- Grieving
- Anxiety/Panic Attacks
- Bipolar syndrome
- PMS/Menopause difficulties
- Poor sleep/Insomnia
- Allergies affecting:
  - Facial skin
  - Body skin
  - Nose/Sinuses
  - Eyes
  - Stomach/Gut
- Orthopedic pins or plates
- Other: \_\_\_\_\_

**Exercise**

Time/day-week: \_\_\_\_\_ Activities: \_\_\_\_\_

The above information is accurate. I understand that Massage Therapists do not diagnose disease or prescribe drugs and that they are not a substitute for medical care. I agree to alert my practitioner of any physical/emotional changes as they occur. I also understand that a missed appointment might incur charges that I must pay.

Signature \_\_\_\_\_ Date \_\_\_\_\_