Registration/Health History

Date_____

Name_____

Address _____

City, State, Zip _____

Phone: home_____ Cell_____

Email _____

For appointment reminders, newsletter, special offers

How did you find us?_____

Birth date_____ Age _____Marital status: M/ S/ W/ D

Employer _____

Occupation _____

Emergency Contact _____

Phones: Home_____ cell_____

Primary Health care Provider

Name _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

Permission to consult with primary provider Yes ☐ No ☐

Massage History/Treatment Information

What results do you intend from your massage sessions?

_____

Have you ever received massage/manual therapy before?

Yes ☐ No ☐ Frequency _____

Results _____

List treatment concerns, check all that apply

Primary _____

Mild ☐ Moderate ☐ Disabling ☐

Constant ☐ Intermittent ☐

Symptoms ↑with activity ☐ ↓with activity ☐

Getting worse ☐ Improving ☐ No change ☐

Treatment received/remedies tried_____

_____

Secondary _____

Mild ☐ Moderate ☐ Disabling ☐

Constant ☐ Intermittent ☐

Symptoms ↑with activity ☐ ↓with activity ☐

Getting worse ☐ Improving ☐ No change ☐

Treatment received/remedies tried_____

_____

Additional _____

Mild ☐ Moderate ☐ Disabling ☐

Constant ☐ Intermittent ☐

Symptoms ↑with activity ☐ ↓with activity ☐

Getting worse ☐ Improving ☐ No change ☐

Treatment received/remedies tried_____

_____

Please ***initial*** each area of the body you consent to receive massage. Back ____ Legs _____ buttocks ____ arms ____ chest _____ Abdomen _____ Neck _____ head _____ face _____

List stress reducing and exercise activities, include frequency

_____

_____

Daily Activities (typical day)

Work (type) _____

Home/family _____

Social/recreational _____

On the above list circle all activities affected by your current condition. All of the above ☐

Other activities affected washing ☐ dressing ☐ fitness ☐ Sleep ☐

Health History/Information

List all conditions currently monitored by a health care professional _____

_____

_____

List and explain, include dates and treatment received

Surgeries _____

_____

Major Illnesses_____

_____

Accidents _____

_____

List **all** medications, including supplements, pain relievers and herbal remedies_____

_____

_____

General

Current	Past	Comments
☐	☐	Headaches _____
☐	☐	Pain _____
☐	☐	Sleep Disturbance _____
☐	☐	Fatigue _____
☐	☐	Infection _____
☐	☐	Fever _____
☐	☐	Sinus _____
☐	☐	Other _____

Habits

Current	Past	Comments
☐	☐	Tobacco_____Pack per_____
☐	☐	Alcohol_____Drinks per day_____
☐	☐	Drugs _____
☐	☐	Coffee/tea _____Cups per day_____
☐	☐	Soda_____Oz per day_____

Skin Conditions

Current	Past	
☐	☐	Rashes_____
☐	☐	Athlete's foot_____
☐	☐	Warts/Skin lesions_____
☐	☐	Acne/Boils _____

Allergies

Current	Past	
☐	☐	**Nuts/food**
☐	☐	Detergents/ latex
☐	☐	Scents/oils/lotions
☐	☐	Other _____

Muscles and Joints

Current	Past	
☐	☐	rheumatoid arthritis
☐	☐	Osteoarthritis
☐	☐	Osteoporosis
☐	☐	Scoliosis
☐	☐	Broken bones
☐	☐	Spinal problems
☐	☐	Disk problems
☐	☐	TMJ/jaw pain
☐	☐	Spasms, cramps
☐	☐	Sprains, strains
☐	☐	Tendonitis, bursitis
☐	☐	Stiff/painful joints
☐	☐	Weak/sore muscles
☐	☐	Neck/shoulder/arm pain
☐	☐	Low back/hip/leg pain
☐	☐	Other _____

Nervous system

Current	Past	
☐	☐	Head injury, concussion
☐	☐	Dizziness/ringing in ears
☐	☐	Loss of memory confusion
☐	☐	Numbness tingling

Where?_____

☐	☐	Sciatica, shooting pain
☐	☐	Chronic pain
☐	☐	Depression
☐	☐	Fibromyalgia
☐	☐	Shingles/herpes
☐	☐	Other _____

Respiratory/Cardiovascular

Current	Past	
☐	☐	**High blood pressure**
☐	☐	**Low blood pressure**
☐	☐	Heart disease
☐	☐	Blood clots
☐	☐	Stroke
☐	☐	Lymphedema
☐	☐	Irregular heart beat
☐	☐	Poor circulation
☐	☐	Swollen ankles
☐	☐	Varicose veins
☐	☐	Chest pain,
☐	☐	shortness of breath, asthma
☐	☐	Other _____

Digestive/Elimination system

Current	Past	
☐	☐	Bowel dysfunction
☐	☐	Gas, bloating
☐	☐	Bladder/kidney dysfunction
☐	☐	Constipation
☐	☐	Abdominal Pain
☐	☐	Other _____

Endocrine system

Current	Past	
☐	☐	Thyroid dysfunction
☐	☐	Diabetes
☐	☐	Lupus
☐	☐	Other _____

Reproductive system

Current	Past	
☐	☐	Pregnancy
☐	☐	Painful, emotional menses
☐	☐	Menopause
☐	☐	Fibrotic cysts
☐	☐	Other _____

Cancer/Tumors

Current	Past	
☐	☐	Benign
☐	☐	Malignant
☐	☐	Other _____

It is my choice to receive massage therapy and consent to receive treatment. I realize that the treatment is given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, and for increasing circulation or energy flow.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, medications, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I understand that therapeutic massage can be uncomfortable at times and that soreness in the days following can occur; and in rare cases, bruising.

I agree to participate in the self-care program recommended to me.

I have reported all health conditions that I am aware of and will inform my practitioner of any changes.

I understand the cancellation policy and know I will be charged the full value of the appointment reserved for appointments cancelled/rescheduled without 24 hours notice.

Signature _____ Date _____