

DATE: _____

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

OCCUPATION: _____

CONTACT IN CASE OF EMERGENCY: _____ PHONE: _____

PHYSICIAN/S: _____ PHONE: _____

(Please include Orthopedic _____ PHONE: _____

OB/GYN, Chiropractor, etc.) _____ PHONE: _____

ACTIVITIES, HOBBIES, EXERCISE, SPORTS, STRESS REDUCTION _____

PREVIOUS EXPERIENCE WITH MASSAGE (TYPE, HOW OFTEN IF ANY) _____

PRIMARY REASON FOR TODAY'S APPOINTMENT:
(AREAS OF PAIN, DYSFUNCTION, TENSION) _____

(CAUSE IF KNOWN, SUSPECTED) _____

PLEASE LIST ALL SURGERIES: _____

ACCIDENTS: _____

ARE YOU WEARING CONTACTS?	YES	NO
ARE YOU WEARING DENTURES?	YES	NO

PLEASE MARK (X) ALL CONDITIONS THAT APPLY NOW. PUT A (P) FOR PAST CONDITIONS. PUT A (F) FOR FAMILY HISTORY OF ILLNESS:

- | | | |
|--|--|---|
| <input type="checkbox"/> headaches, migraines | <input type="checkbox"/> chronic pain | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> vision problems, contact lenses | <input type="checkbox"/> muscle or joint pain | <input type="checkbox"/> tension, stress |
| <input type="checkbox"/> hearing problems, deafness | <input type="checkbox"/> muscle, bone injuries | <input type="checkbox"/> depression |
| <input type="checkbox"/> injuries to face or head | <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> sleep difficulties |
| <input type="checkbox"/> sinus problems | <input type="checkbox"/> sprains, strains | <input type="checkbox"/> allergies, sensitive |
| <input type="checkbox"/> dental bridges | <input type="checkbox"/> arthritis, tendonitis | <input type="checkbox"/> rash, athlete's foot |
| <input type="checkbox"/> jaw pain, TMJ problems | <input type="checkbox"/> cancer, tumors | <input type="checkbox"/> infectious disease |
| <input type="checkbox"/> asthma or lung conditions | <input type="checkbox"/> spinal column disorders | <input type="checkbox"/> blood clots |
| <input type="checkbox"/> constipation, diarrhea | <input type="checkbox"/> diabetes | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> hernia | <input type="checkbox"/> pregnancy | <input type="checkbox"/> birth control/IUD |
| <input type="checkbox"/> high/low blood pressure | <input type="checkbox"/> heart/circulatory problems | |
| <input type="checkbox"/> abdominal or digestive problems | <input type="checkbox"/> other medical problems not listed above | |

EXPLAIN ANY AREAS NOTED ABOVE: _____

CURRENT MEDICATIONS: (include aspirin, ibuprofen, herbs, vitamins, etc.) _____

MASSAGE THERAPIST NOTES: _____

I have truthfully answered the above statements to the best of my knowledge.

Signature: _____ Date: _____