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 TODAYS 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:

___headaches, migraines
___vision problems, contact lenses
___hearing problems, deafness
___injuries to face or head
___sinus problems
___dental bridges
___jaw pain, TMJ problems
___asthma or lung conditions
___constipation, diarrhea
___hernia
___high/low blood pressure
___abdominal or digestive problems
___chronic pain
___muscle or joint pain
___muscle, bone injuries
___numbness or tingling
___sprains, strains
___arthritis, tendonitis
___cancer, tumors
___spinal column disorders
___diabetes
___pregnancy
___heart/circulatory problems
___other medical problems not listed above
___fatigue
___tension, stress
___ depression
___sleep difficulties
___allergies, sensitive
___rash, athlete's foot
___infectious disease
___blood clots
___varicose veins
___birth control/IUD

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:_____