Enjoy being

Acupuncture & Massage Therapy

...harmonizing health through touch

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Massage Therapy

Personal Health Inquiry

All information provided will remain confidential

Name _____ Date _____

Phone (____) _____ Email _____

Address _____ City _____ State _____ Zip _____

Birthdate _____ Occupation _____

Referred by _____ Emergency Contact _____

General Health Infomation

Do you now or have you ever had any of the following conditons?

(Please list date of diagnosis)

High Blood Pressure _____

Stress Disorders _____

Anxiety _____

Chronic Fatigue _____

Nervous System Disorders _____

Allergies (esp. topical) _____

Diabetes _____

Epilepsy _____

Seizures _____

Arthritis _____

Cancer _____

Fibromyalgia _____

Frequent Headaches _____

TMJ Disorders _____

Stroke _____

Hernia _____

Rashes _____

Cysts/Lumps _____

HIV/AIDS _____

Asthma _____

Tennis Elbow _____

Bursitis _____

Numbness _____

Varicose Veins _____

Fungal Infection _____

Bone Disease _____

Heart Disease _____

Unexplained Inflammation _____

Unexplained Illness _____

Surgeries _____

Health History

Check the following conditions that apply to you, Past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

- ☐ Headaches
- ☐ Joint stiffness/swelling
- ☐ Spasms/Cramps
- ☐ Broken/fractured Bones
- ☐ Strings or sprains
- ☐ Back, hip pain
- ☐ Shoulder, neck, arm, hand pain
- ☐ Leg, foot pain
- ☐ Chest, ribs, abdominal pain
- ☐ Problems walking
- ☐ Jaw pain (TMJ)
- ☐ Tendinitis
- ☐ Bursitis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Bone or joint disease
- ☐ Other _____

Circulatory and Respiratory

- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Cold feet or hands
- ☐ Cold sweats
- ☐ Swollen ankles
- ☐ Pressure sores
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Stroke
- ☐ Heart condition
- ☐ Allergies
- ☐ Sinus problems
- ☐ Asthma
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Lymphedema
- ☐ Other _____

Skin

- ☐ Rashes
- ☐ Allergies
- ☐ Athletes foot
- ☐ Warts
- ☐ Acne
- ☐ Cosmetic surgery
- ☐ Other _____

Digestive

- ☐ Nervous stomach
- ☐ Indigestion
- ☐ Constipation
- ☐ Intestinal gas or bloating
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Irritable bowel syndrome
- ☐ Crohn's disease
- ☐ Colitis
- ☐ Adaptive aids
- ☐ Other _____

Nervous System

- ☐ Numbness/tingling
- ☐ Twitching of the face
- ☐ Fatigue
- ☐ Chronic pain
- ☐ Sleep disorders
- ☐ Ulcers
- ☐ Paralysis
- ☐ Herpes/shingles
- ☐ Cerebral palsy
- ☐ Epilepsy
- ☐ Chronic fatigue syndrome
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Spinal cord injury
- ☐ Other _____

Reproductive System

- ☐ Pregnancy
  - ☐ Current ☐ Previous
- ☐ PMS
- ☐ Menopause
- ☐ Pelvic inflammatory disease
- ☐ Endometriosis
- ☐ Hysterectomy
- ☐ Fertility concerns
- ☐ Prostate problems

Other

- ☐ Loss of appetite
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Difficulty concentrating
- ☐ Drug use
- ☐ Alcohol use
- ☐ Nicotine use
- ☐ Caffeine use
- ☐ Hearing impaired
- ☐ Visually impaired
- ☐ Burning upon urination
- ☐ Bladder infection
- ☐ Eating disorder
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Post Polio Syndrome
- ☐ Cancer
- ☐ Infectious disease (please list)

_____

☐ Other congenital are required disabilities (please list) _____

_____

☐ Surgeries _____

☐ Other _____

Please list any additional comments regarding your health and well-being. _____

_____

Have you had any broken bones? Yes, when and what?

Do you have tension/soreness in any particular area?

Do you suffer from back pain? If so, what part of the back?

Have you ever been in a car accident? If yes, when?

Are you sensitive to touch/pressure in any area? If yes, where?

Do you have cardiac or circulatory problems? If so, please explain.

Have you had massage before? If so, what types?

Are you allergic to any lotion or oils?

Do you have any other medical condition to be aware of? Yes, please explain.

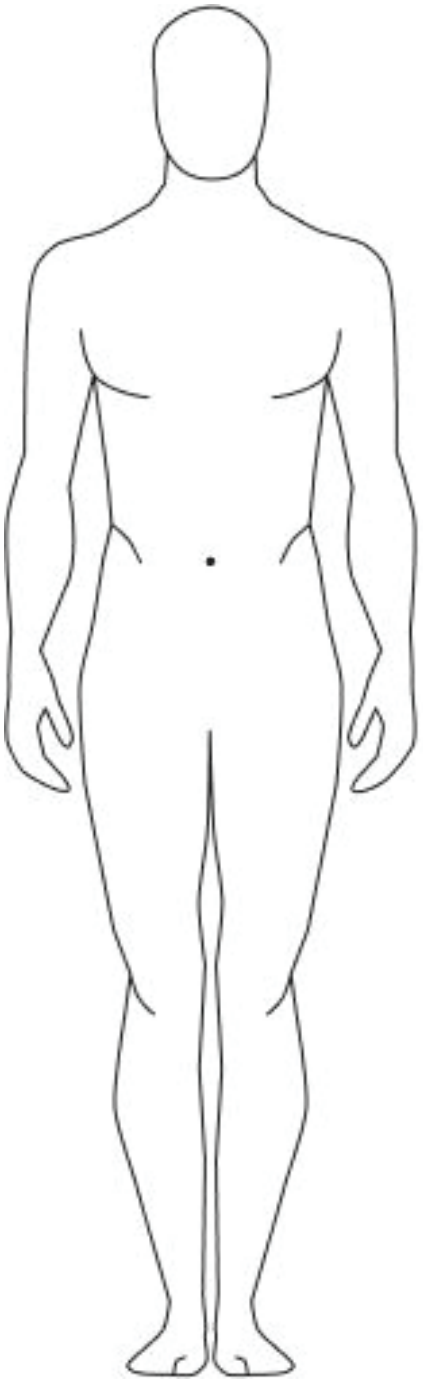
Please list any medications you are on (especially for pain), and their uses and/or side effects:

Comments: Concerns, Questions:

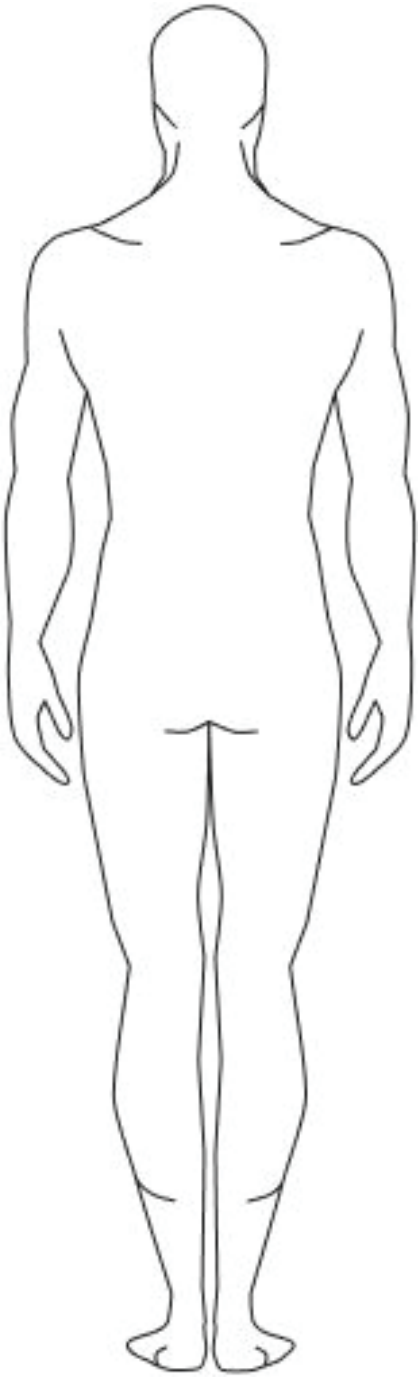
Where do you hold stress in your body?

What is the most prominent emotion you feel today/lately?

What is your main reason for receiving body work?



FRONT



BACK

Please mark accordingly indicating the area(s) of concern. Give a brief description of your current symptoms. Include date condition began:

Massage Consent Form

Please take a moment to carefully read the following information and sign where indicated.

If you have a specific medical condition or specific symptoms, massage may be contraindicated. A referral from your primary care provider may be required to provide services being provided. I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the Practitioner so that the pressure and or strokes may be adjusted to my level of comfort. I further understand that massage therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any medical or physical ailment that I am aware of. I understand that Massage Therapists are not qualified to perform spinal or skeletal adjustments, diagnosis, prescribe or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. Because Massage Therapy is contraindicated under certain medical conditions, I affirm that I have stated all my non-medical conditions and answered all questions honestly, I agree to keep the Practitioner updated as to any changes in my medical profile, I understand that there shall be no liability on the Practitioner's part, should I forget to do so. It is also understood theat any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. I also agree to give a 24 hour notice if I need to cancel my future appointments or pay $60 non cancelation fee.

Patient Signed: _____ Date: _____

Practitioner: _____ Date: _____

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