Massage by Shannon

Massage Therapy

Date_____

Personal Information

Name _____

Address _____

City _____ State____ Zip_____

Phone _____

Alternate Phone _____

Email address _____

Date of Birth _____

Emergency Contact _____

Phone _____

Referred By _____

Current Health Information

Primary Care Provider _____

Medications _____

_____

_____

Please list health concerns

Primary_____

Onset _____

☐mild ☐moderate ☐disabling

☐constant ☐intermittent

Symptoms w/activity ☐increase ☐decrease

☐getting worse ☐getting better ☐no change

☐treatment received _____

_____

Secondary _____

Onset _____

☐mild ☐moderate ☐disabling

☐constant ☐intermittent

Symptoms w/activity ☐increase ☐decrease

☐ getting worse ☐getting better ☐no change

☐treatment received

Have you ever received massage therepy?

☐Yes ☐no how recently _____

Daily Activities

Work _____

_____

Home/family_____

_____

Social/Recreational_____

_____

List all activities affected by your condition _____

_____

What are you intake of: (*none, light, moderate, heavy*)

Water_____ salt_____

Sugar_____ caffeine_____

Alcohol_____ tobacco_____

Exercise_____

How do you reduce stress? _____

_____

How do you reduce pain? _____

_____

What are your goals for receiving therapy? _____

_____

_____

Health History

List and explain. Include dates and treatment.

Surgeries _____

_____

_____

Accidents (list details such as place of impact and head direction, it applicable) _____

_____

_____

_____

_____

_____

_____

Check All Currant and Previous Conditions Please Explain

General

☐Headaches _____
☐Pain _____
_____
☐Sleep disturbances _____
☐Fatigue _____
☐Fever _____
☐Sinus _____

Skin Conditions

☐Rashes _____
☐Athlete's Foot, warts _____

Allergies

☐Scents, oils, lotions _____
☐Detergents _____

Muscles and Joints

☐Rheumatoid arthritis _____
☐Osteoarthritis _____
☐Osteoporosis _____
☐Scoliosis _____
☐Broken bones _____
_____
☐Spinal problems _____
_____
☐Disk problems _____
_____
☐TMJ, Jaw Pain _____
☐Spasms, Cramps _____
_____
☐Sprains, Strains _____
_____
☐Tendonitis, Bursitis _____
☐Stiff/painful joints _____
_____
☐Weak or sore muscles _____
_____
_____
☐Neck, shoulder, arm pain _____
_____
_____
☐Lower back, hip, leg pain _____
_____
_____

Nervous System

☐Head injuries, Concussions _____
_____
☐Dizziness, ringing in the ears _____
_____
☐Loss of memory, Confusion _____
_____
☐Numbness tingling _____
_____
_____
☐Sciatica, shooting Pain _____
_____
☐Chronic pain _____
_____
☐Depression _____
☐Other _____

Respiratory

☐Heart disease _____
_____
☐Blood clots _____
☐Stroke _____
☐High, low blood pressure _____
_____
☐Irregular heart beat _____
☐Poor circulation _____
_____
☐Swollen ankles _____
☐Varicose veins _____
☐Chest pain, shortness of breath ___
_____
☐Asthma _____

Digestive System

☐Bowed dysfunction _____
☐Gas, bloating _____
☐Bladder, Kidney dysfunction ____
☐Abdominal pain _____
☐Other _____

Other

Please list any other health concerns not listed above _____
_____
_____
_____
_____

I understand that the massage therapy I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my sessions, 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 mental or physical ailment of which I am aware. I understand that massage therapy practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health. I understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that 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. It is my choice to receive massage therapy and I give my consent to receive treatment.

Signature _____ Date _____