

Joy McCall
Licensed Massage & Bodywork Therapist
(NC 5768)

Personal Information

Date _____ Date of Birth _____

Name _____ Referred by _____

Address _____

City _____ State _____ Zip _____

Phone (Home) _____ (Work) _____

(Cell) _____ Email _____

Emergency Contact _____ Emergency Phone _____

Employer _____ Occupation _____

Work Responsibilities _____

Current Health

Have you ever received massage therapy before? Yes ___ No ___ Frequency: _____

Reason for today's session: _____

Today's Primary Goal: _____ Other: _____

Classify concern: Minor ___ Problematic ___ Major ___

Classify type: Recurring ___ Getting worse ___ Getting better ___

Have you had this concern/goal before? Yes ___ No ___ Explain: _____

Have you received treatment for this before? Yes ___ No ___ Explain: _____

List of activities affected: _____

Current Medications: _____

(Include over-the-counter pain relievers and herbal remedies)

Current health continued

Stress reduction/exercise activities: _____ Frequency: _____

Check any of the following that apply to your current health:

____ pregnancy ____ heart conditions ____ Circulatory conditions ____ blood clots
____ diabetes ____ infections ____ cancer ____ difficulty breathing ____ arthritis

Comments: _____

Is there anything I should know to ensure your comfort regarding: _____

Allergies/sensitivities: oils ____ lotions ____ scents ____ detergents ____ foods ____ animals ____

Other: _____

Contact lenses (the face pillow may put pressure on your eyes): _____

Hearing abilities (communication is helpful during the session): _____

Hair, makeup, clothes (will you return to work after your session?): _____

Movement abilities (i.e., getting on and off the table, pillows, etc.): _____

Comments: _____

Mark on figures all areas of:

Pain, tenderness with O's

Numbness, tingling with ZZ's

Swelling, stiffness with X's

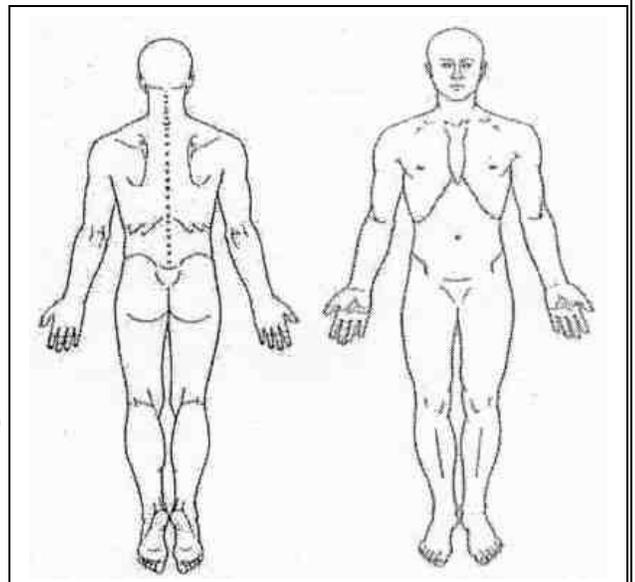
Scars, bruises, open wounds with HH's

Rate severity of all areas from 1-10:

(1= I feel like a newborn baby, 10= put me out of my misery)

1 2 3 4 5 6 7 8 9 10

Comments: _____



Consent for care

I understand that certain treatments may be contraindicated if I have a specific medical condition or specific symptom. I understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should seek assistance from a medical specialist for any ailment of which I am aware. I understand that massage/bodywork therapist are not qualified to 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 stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Signature _____ Date _____