Massage Patient Information

Name: ______________________ DOB: ____________

Address: ______________________ Phone: ____________

City: __________ State: _____ Zip: _______ Occupation: ______________

Circle any of the following you have **today:**

Cold/Flu	Open cuts, bruises, burns	Inflammation
Fever	Irritated skin rash	Poison Ivy
Headache	Severe Pain	Sun Burn

General Health Condition:___ ______________Normal Blood Pressure: YES/NO

Sports, exercise, or other physical activity: ______________________

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Indicate consumption of the following (O=None, 1=Light, 2=Moderate, 3=Heavy)

Salt	Sugar	Caffeine	Tobacco	Alcohol	Water

Any serious injury, illness, or surgery (including the spine or joints?): ______________

____

Are you in recovery for any addictions or abuse? YES/NO

Are you currently seeing a Doctor, Chiropractor, or Physical therapist? YES/NO

If so, for what condition? ______________________

Are you taking any medication? YES/NO If yes, for: ______________

Do I have permission to contact your Doctor or Therapist if necessary? YES/NO

If yes, contact information: Name: ______________ Phone: ____________

In case of Emergency, please contact:

Name: ______________________ Relation: ______________

Phone: ______________________

Massage Therapy Information

Have you had massage therapy before? YES/NO

Did you find it helpful? YES/NO

You came today for: Therapy, Pain relief, Relaxation, Other: ____________

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How did you discover this service? ____________________________

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Circle any that apply:

Back Pain	Joint aches/pain	Diabetes
Disk Problems	Sprains	Arthritis, Bursitis, Gout
Neck Pain	Decreased range of motion	Cancer
Headaches	Abdominal Pain	Heart Attack or Stroke
Stress	IBS/Colitis	HIV/Hepatitis
Broken Bones	Varicose Veins	Auto Accident/Whiplash
Pregnant	Orthotics	Allergy to Oils/Liniments

Provide information on the symptoms listed below:

Symptom	**Location**	**How Long?**	**How Often?**	**Comments:**
Pain				
Soreness				
Muscle Spasm				
Numbness				
Burning				
Other				

I have completed this information to the best of my knowledge. I understand that massage services are designed to be a health aid and do not take the place of a physician's care when indicated information exchanged during any massage session is intended to help me become more familiar with my own health status and is to be used at my discretion. All information shared on this form or during therapy session is completely confidential.

Signature: ______________________________ Date: ____________