CONFIDENTIAL INFORMATION

Welcome. We want to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your therapy session, please let us know.

Patient Information:

Name: ____________________ Home #: ____________ Cell #: ____________

Address: ____________________ City: ____________ State: ___ Zip: ________

E-mail: ____________________ Sex: M__ F__ Birthdate: ____________

Occupation: ____________________ Work #: ____________________

Whom may we thank for referring you? ____________________

Have you ever received massage therapy? No ___ Yes ___ Date: ____________

Type of massage experienced: Swedish ___ Deep Tissue ___ Other ____________

In Case of Emergency Name: ____________________ Phone #: ____________

Health History:

What treatment have you already received for your condition? Surgery _____ Physical therapy _____ Chiropractic services_____ Other _____

Name of Primary Physician: ____________________ Phone: ____________

Name of Chiropractor: ____________________ Phone: ____________

Do you have a history of the following:

Accidents/injuries		Fibromyalgia	
Surgery		Asthma/respiratory conditions	
Vertebral/disc problems		Allergies	
Whiplash		Skin conditions/excema/rash	
Headaches/migraines		Diabetes	
Broken bones		Bleeding/bruising	
Sprains/strains		Varicose veins/phlebitis	
Arthritis/bursitis		High/low blood pressure	
Numbness		Stroke	
Carpel tunnel syndrome		Heart attack/cardiac conditions	
Sciatica		Cancer/tumors	
Scoliosis		Colitis/digestive conditions	
Seizures/epilepsy		Hepatitis/HIV	
Anxiety/panic attacks		Kidney/urinary conditions	
Depression/bipolar disorder		Liver/gallbladder conditions	

Please list any medications that you are taking ____________________

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Are you pregnant? Yes _____ No _____ Due Date: ____________

Exercise: None _______ Moderate _______ Daily _______ Heavy _______

Work Activity: Sitting ______ Standing ______ Light labor ______ Heavy labor ______

Habits:
- Smoking ______ Packs/Day ____________
- Alcohol ______ Drinks/Week ____________
- Coffee/Caffeine drinks _____ Cups/Day ____________
- High Stress Level _____ Reason ____________

Patient Condition:

How often do you have this pain?____

Does it interfere with your work___ sleep ___ daily routine ___ recreation___

Activities or movements that are painful to perform:

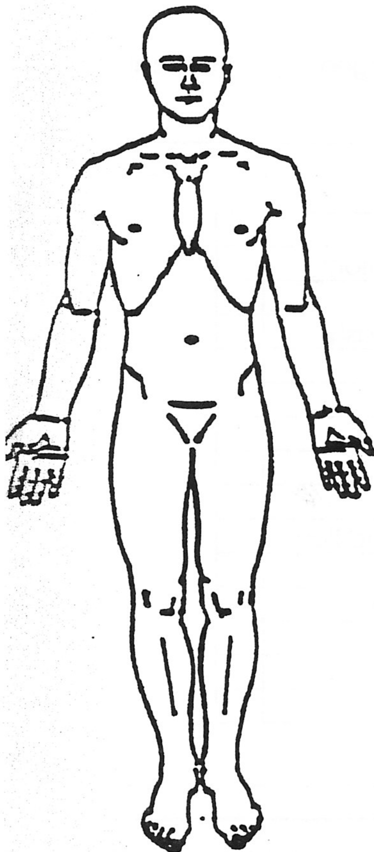
Sitting ___ Standing ____ Walking____ Bending____ Lying down ____

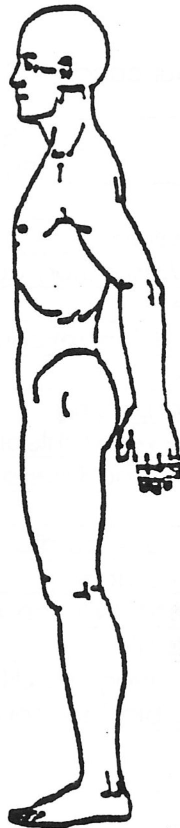
Mark an X on the picture where you continue to have pain, numbness, or tingling.

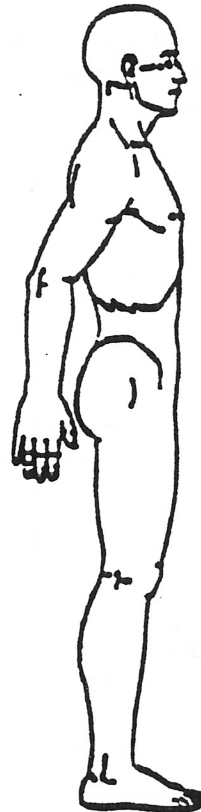
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)______

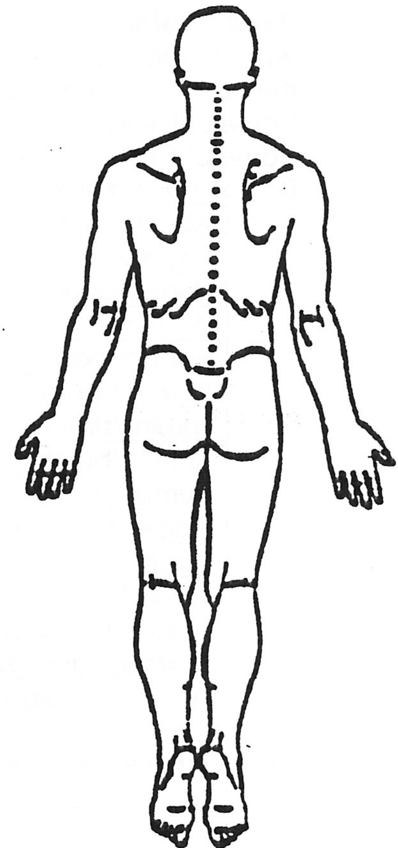
Type of pain: Sharp____ Dull ____ Throbbing ____ Numbness ____ Aching ____
Shooting ____ Burning ____ Tingling ____ Cramps ____ Stiffness ____
Swelling ____ Other ________________________

FRONT **LEFT SIDE** **RIGHT SIDE** **BACK**









What are your goals/expectations for this session? ____________________________

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Please read the following and sign below:

- I understand that this massage is not a replacement for medical care and that no diagnosis will be made.
- **I am responsible for paying any appointment cancellation of less than 24 hours.**

Signature____ Date______________