

# 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.

NAME \_\_\_\_\_ HOME # \_\_\_\_\_ WORK # \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

OCCUPATION \_\_\_\_\_ REFERRED BY \_\_\_\_\_

HAVE YOU EVER RECEIVED MASSAGE THERAPY? YES  NO

TYPE OF MASSAGE EXPERIENCED:  DEEP TISSUE  SWEDISH  OTHER \_\_\_\_\_

ARE YOU TAKING MEDICATION? \_\_\_\_\_ DESCRIBE \_\_\_\_\_

ARE YOU PREGNANT? \_\_\_\_\_

HAVE YOU CONSUMED ALCOHOL IN THE PAST 24 HOURS? YES  NO

DO YOU HAVE A HISTORY OF THE FOLLOWING?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> accident                     | <input type="checkbox"/> sprains                          | <input type="checkbox"/> mastectomy          |
| <input type="checkbox"/> neck pain                    | <input type="checkbox"/> seizures                         | <input type="checkbox"/> breast augmentation |
| <input type="checkbox"/> whiplash                     | <input type="checkbox"/> abdominal pain                   | <input type="checkbox"/> diabetes            |
| <input type="checkbox"/> headaches                    | <input type="checkbox"/> nervous tension                  | <input type="checkbox"/> varicose veins      |
| <input type="checkbox"/> shoulder pain                | <input type="checkbox"/> arthritis, bursitis or<br>gout   | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> upper back pain              | <input type="checkbox"/> allergies to oils or<br>perfumes | <input type="checkbox"/> stroke              |
| <input type="checkbox"/> mid back pain                | <input type="checkbox"/> wear contacts                    | <input type="checkbox"/> heart attack        |
| <input type="checkbox"/> low back pain                | <input type="checkbox"/> scoliosis                        | <input type="checkbox"/> cancer              |
| <input type="checkbox"/> joint ache                   | <input type="checkbox"/> surgery                          | <input type="checkbox"/> colitis             |
| <input type="checkbox"/> decreased range<br>of motion | <input type="checkbox"/> fibromyalgia                     | <input type="checkbox"/> HIV                 |
| <input type="checkbox"/> broken bones                 | <input type="checkbox"/> carpal tunnel syndrome           | _____  |
| <input type="checkbox"/> sciatica                     |   | _____  |

Please indicate your consumption level:

	None	Light	Moderate	Heavy
salt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DO YOU HAVE ANY OF THE FOLLOWING TODAY:

- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> sunburn      | <input type="checkbox"/> open cuts, bruises, burns |
| <input type="checkbox"/> inflammation | <input type="checkbox"/> irritated skin rash       |
| <input type="checkbox"/> severe pain  | <input type="checkbox"/> poison ivy                |
| <input type="checkbox"/> headache     | <input type="checkbox"/> cold/flu                  |

WHAT ARE YOUR GOALS/EXPECTATIONS FOR THIS THERAPY SESSION?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 for any appointment cancellation of less than 24 hours.

DATE: \_\_\_\_\_ SIGNATURE \_\_\_\_\_

PLEASE INDICATE WITH AN (X), THE AREAS YOU ARE FEELING DISCOMFORT

