Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male/Female (circle)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact & Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a professional massage before? YES NO

Daily activities/sports/hobbies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History** – Please indicate and elaborate below any significant medical problems, as such conditions can influence the type and/or depth of work done in any given area. Thank you.

**Skin Conditions:**

\_\_\_\_\_ Acne

\_\_\_\_\_ Cellulitis

\_\_\_\_\_ Dermatitis

\_\_\_\_\_ Eczema

\_\_\_\_\_ Hives

\_\_\_\_\_ Psoriasis

\_\_\_\_\_ Rosacea

\_\_\_\_\_ Other

**Respiratory Conditions:**

\_\_\_\_\_ Asthma

\_\_\_\_\_ Bronchitis

\_\_\_\_\_ Chronic Cough

\_\_\_\_\_ Cystic Fibrosis

\_\_\_\_\_ Emphysema

\_\_\_\_\_ Pneumonia

\_\_\_\_\_ Pulmonary Fibrosis

\_\_\_\_\_ Shortness of Breath

\_\_\_\_\_ Sinusitis

\_\_\_\_\_ Other

**Cardiovascular Conditions:**

\_\_\_\_\_ Atherosclerosis

\_\_\_\_\_ Congestive Heart Failure

\_\_\_\_\_ Heart Attack

\_\_\_\_\_ Hemophilia

\_\_\_\_\_ High/Low Blood Pressure

\_\_\_\_\_ Pacemaker

\_\_\_\_\_ Phlebitis / Varicose Veins

\_\_\_\_\_ Stroke

\_\_\_\_\_ Other Heart Disease(s)

**Nervous System Conditions:**

\_\_\_\_\_ Alzheimer’s Disease

\_\_\_\_\_ Ataxia

\_\_\_\_\_ Cerebral Palsy

\_\_\_\_\_ Epilepsy / Seizures

\_\_\_\_\_ Guillan-Barre Syndrome

\_\_\_\_\_ Lou Gehrig’s Disease \_\_\_\_\_ Meningitis

\_\_\_\_\_ Multiple Sclerosis (MS)

\_\_\_\_\_ Numbness / Tingling

\_\_\_\_\_ Parkinson’s Disease

\_\_\_\_\_ Peripheral Neuropathy

\_\_\_\_\_ Sensory Loss / Change

\_\_\_\_\_ Tourette’s Syndrome

\_\_\_\_\_ Other

**Head/Neck Conditions:**

\_\_\_\_\_ Concussion(s)

\_\_\_\_\_ Headaches / Migraines

\_\_\_\_\_ Hearing Problems

\_\_\_\_\_ Ringing Ears

\_\_\_\_\_ Skull Fracture(s)

\_\_\_\_\_ Vertigo / Dizziness

\_\_\_\_\_ Vision Problems

\_\_\_\_\_ Other

**Mental Conditions:**

\_\_\_\_\_ Anxiety

\_\_\_\_\_ Depression

\_\_\_\_\_ Psychiatric Disorder

\_\_\_\_\_ PTSD

\_\_\_\_\_ Other

**Musculoskeletal Conditions:**

\_\_\_\_\_ Artificial Joints

\_\_\_\_\_ Bursitis

\_\_\_\_\_ Carpal Tunnel Syndrome

\_\_\_\_\_ Frozen Shoulder

\_\_\_\_\_ Golfer’s Elbow

\_\_\_\_\_ Gout

\_\_\_\_\_ Herniated Disc(s)

\_\_\_\_\_ Nerve Impingement

\_\_\_\_\_ Osteoarthritis

\_\_\_\_\_ Osteopenia

\_\_\_\_\_ Osteoporosis

\_\_\_\_\_ Pins / Plates

\_\_\_\_\_ Piriformis Syndrome

\_\_\_\_\_ Previous Surgery

\_\_\_\_\_ Retrolisthesis

\_\_\_\_\_ Rheumatoid Arthritis

\_\_\_\_\_ Sciatica

\_\_\_\_\_ Scoliosis

\_\_\_\_\_ Shin Splints

\_\_\_\_\_ Spondylolisthesis

\_\_\_\_\_ Sprain / Strain

\_\_\_\_\_ Stenosis

\_\_\_\_\_ Tarsal Tunnel Syndrome

\_\_\_\_\_ Tendinitis

\_\_\_\_\_ Tennis Elbow

\_\_\_\_\_ TMJ Disorder

\_\_\_\_\_ Whiplash

\_\_\_\_\_ Other

**Reproductive Conditions:**

\_\_\_\_\_ Chlamydia

\_\_\_\_\_ Erectile Dysfunction

\_\_\_\_\_ Gonorrhea

\_\_\_\_\_ Gynecological Problems

\_\_\_\_\_ Loss of Libido

\_\_\_\_\_ Pelvic Inflam. Disease

\_\_\_\_\_ PMS

\_\_\_\_\_ Pregnant

\_\_\_\_\_ Prostate Problems

\_\_\_\_\_ Herpes

\_\_\_\_\_ Syphilis

\_\_\_\_\_ Warts

\_\_\_\_\_ Other

**Digestive Conditions:**

\_\_\_\_\_ Celiac Disease

\_\_\_\_\_ Crohn’s Disease

\_\_\_\_\_ Constipation

\_\_\_\_\_ Diverticulitis/-osis

\_\_\_\_\_ Gastroparesis

\_\_\_\_\_ Inflam. Bowel Disease

\_\_\_\_\_ Irritable Bowel Syndrome

\_\_\_\_\_ Reflux Disease (GERD)

\_\_\_\_\_ Other

**Other Conditions:**

\_\_\_\_\_ Allergies

\_\_\_\_\_ Cancer

\_\_\_\_\_ Chronic Fatigue Syndrome

\_\_\_\_\_ Diabetes Type I / II

\_\_\_\_\_ Fibromyalgia

\_\_\_\_\_ Hepatitis A / B / C

\_\_\_\_\_ Hypo- / Hyperglycemia

\_\_\_\_\_ Hypo- / Hyperlipidemia

\_\_\_\_\_ Hypo- / Hyperthyroidism

\_\_\_\_\_ Kidney Disease(s)

\_\_\_\_\_ Lyme Disease

\_\_\_\_\_ Lymphedema

\_\_\_\_\_ Obesity

\_\_\_\_\_ Tuberculosis

\_\_\_\_\_ Other

Please elaborate on any of the above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Are you currently taking any medications? YES NO

If so, please list (dose, dosage, & condition treated): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? YES NO Consume alcohol? YES NO Sexually active? YES NO

How were you referred to us? (Please circle): Website Google Social Media Friend Doctor Other

Would you like to receive emails featuring newsletters, discounts, and promotions? YES NO

**Consent of Care**

I hereby state that, to the best of my knowledge, my answers to the above questions are correct. I agree and consent to assessment and treatment. I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment. I understand that it is my responsibility to confirm the exact details of my coverage.

I have been provided with descriptions of the service and anticipated benefits. I understand and agree to the purpose, nature, and duration of the proposed service, and consent to receive this service. I understand that there can be remote risks associated with massage therapy. I acknowledge that the practitioner will not be held responsible for any injury arising because of an unreported condition, concern, or negligence on part of the practitioner. I acknowledge being given the opportunity to ask questions before receiving any work, and to question or interrupt the work at any point after the session begins. I acknowledge having read and understood this document and freely give consent for treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Parent/Guardian if under 18