

Patient information

Name _____

Date of birth _____ Today's date _____

Address _____ Apt# _____

City _____ State _____ Zip _____

Cell phone _____ Work phone _____ Home phone _____

E-mail _____ Occupation _____

Emergency contact _____ Their phone _____

Current health concerns

Primary health concern _____

☐ mild ☐ moderate ☐ disabling ☐ getting worse ☐ getting better ☐ no change
☐ constant ☐ intermittent ☐ feels better with activity ☐ feels worse with activity
treatment received _____

Secondary health concern _____

☐ mild ☐ moderate ☐ disabling ☐ getting worse ☐ getting better ☐ no change
☐ constant ☐ intermittent ☐ feels better with activity ☐ feels worse with activity
treatment received _____

Other health concerns _____

☐ mild ☐ moderate ☐ disabling ☐ getting worse ☐ getting better ☐ no change
☐ constant ☐ intermittent ☐ feels better with activity ☐ feels worse with activity
treatment received _____

Activities

Are any of your daily activities limited by your condition?

Work _____ Home/family _____

Sleep/self-care _____ Social/recreational _____

How do you reduce stress? _____ Pain? _____

Current medications (including pain relievers and herbal remedies) _____

Have you ever received massage therapy before? How often? _____

What are your goals for receiving massage therapy? _____

How did you hear about me? ☐ Google ☐ Yelp ☐ Healthpros ☐ Referred by someone

☐ Other _____

Health history

Have you had any **surgeries**? For what? When? _____

Have you had any **injuries** or **major illnesses**? What and when? _____

Please check any conditions and provide explanations if needed, including if the condition is **current or in the past**.

General

- ☐ headaches _____
- ☐ pain _____
- ☐ sleep disturbances _____
- ☐ fatigue _____
- ☐ infections _____
- ☐ fever _____
- ☐ sinus _____
- ☐ other _____

Muscles and joints

- ☐ rheumatoid arthritis _____
- ☐ osteoarthritis _____
- ☐ osteoporosis _____
- ☐ scoliosis _____
- ☐ broken bones _____
- ☐ spinal problems _____
- ☐ disk problems _____
- ☐ lupus _____
- ☐ TMJ, jaw pain _____
- ☐ spasms, cramps _____
- ☐ sprains, strains _____
- ☐ tendonitis, bursitis _____
- ☐ stiff or painful joints _____
- ☐ weak or sore muscles _____
- ☐ neck, shoulder, arm pain _____
- ☐ low back, hip, leg pain _____

Nervous system

- ☐ head injuries, concussions _____
- ☐ dizziness, ringing in ears _____
- ☐ loss of memory, confusion _____
- ☐ numbness, tingling _____
- ☐ sciatica, shooting pain _____
- ☐ chronic pain _____
- ☐ depression _____
- ☐ other _____

Habits

- ☐ tobacco _____
- ☐ alcohol _____
- ☐ drug _____
- ☐ coffee, soda _____

Respiratory, cardiovascular systems

- ☐ heart disease _____
- ☐ blood clots _____
- ☐ stroke _____
- ☐ lymphedema _____
- ☐ high or low blood pressure _____
- ☐ irregular heartbeat _____
- ☐ poor circulation _____
- ☐ swollen ankles _____
- ☐ varicose veins _____
- ☐ chest pain, shortness of breath _____
- ☐ asthma _____

Skin conditions

- ☐ rashes _____
- ☐ athlete's foot, warts _____
- ☐ other _____

Digestive system

- ☐ bowel problems _____
- ☐ gas, bloating _____
- ☐ bladder/kidney/prostate _____
- ☐ abdominal pain _____

Endocrine/reproductive systems

- ☐ thyroid _____
- ☐ diabetes _____
- ☐ pregnancy _____
- ☐ painful, emotional menses _____
- ☐ fibrotic cysts _____

Cancer/tumors

- ☐ benign _____
- ☐ malignant _____

Consent for care

- I have completed this form to the best of my knowledge and will inform the massage therapist of any change in my physical health.
- I understand that a massage therapist cannot diagnose illness, disease, or any other medical, physical, or emotional disorder, nor perform any spinal or skeletal manipulations. I am responsible for consulting a qualified physician for any physical ailments that I have.
- If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes can be adjusted to my level of comfort.
- I understand that massage therapy is a therapeutic health aid and is non-sexual.
- I understand that there is a 24-hour cancellation policy. If I cancel after 24 hours, but before 5:00 pm the day before my appointment, I will be charged one-half the session fee. After that, I will be responsible for the session fee in full, unless a friend or family member takes my appointment time.

Signature _____ Date _____



Yes! Receive Rachel's free monthly e-mail newsletter with massage videos, health tips, and massage specials.