

Name _____

Address _____

City _____ State _____ Zip _____

Telephone (home) _____ Work Phone _____

Occupation _____ Employer _____

Spouse's Name _____ Employer _____

Physician _____ Referred By _____

Birth Date _____ Age _____

Primary Reason for Appointment _____

Please answer the following questions by circling the appropriate answer:

Have you ever had a professional
massage before? Yes No

Have you ever had surgery?
If yes, please describe: _____

Do you wear contact lenses? Yes No

Do you wear dentures? Yes No

Do you have any skin problems or
allergies? Yes No

Do you take any prescribed
medication? Yes No

If yes, please describe: _____

Have you suffered an acute injury
recently? Yes No

Do you have varicose veins or
blood clots? Yes No

Do you have arthritis? Yes No

Do you have any heart problems? Yes No

Do you have any spinal problems?
If yes, what was the diagnosis? _____

Are you pregnant? Yes No

Do you have blood pressure problems? Yes No

Do you have any tense or sore areas that
need special attention? Yes No

If yes, please specify: _____

Do you have any other medical condition
that I should be aware of before giving you
massage therapy? Yes No

If yes, please specify: _____

Do you exercise regularly or
participate in any sports? Yes No

If yes, what kind and how often? _____

I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. Massage therapists do not perform any spinal manipulations. It has been made very clear to me that this massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Because a massage therapist must be aware of existing physical conditions, I have stated all known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Signature _____ Date _____