

Medical Massage Specialties

Therapeutic Massage in a Relaxing Atmosphere

CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

First Name: _____ Last Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone Number _____ Appointment Notification/Confirmation: SMS e-mail both

Other Phone _____ Referred by: _____ Found us on: Google Yelp Facebook Other: _____

E-mail: _____ Occupation: _____

Receive emails/newsletter from Medical Massage Specialties Y N Receive text promotions from our team Y N

Emergency contact: _____ Phone: _____ Relationship: _____

Is this your first professional massage? _____ If no, how frequently do you get a massage? _____

What do you hope to accomplish from today's massage? _____

Are there any tension holding spots in your body or have areas you'd like to focus on? Y N If yes, location(s) _____

Please list any sports or regular exercise activities you participate in? _____

Do you have any allergies? Y N If yes, please explain _____

Is the use Essential Oils for Aromatherapy okay during your session? Y N

Describe any surgeries, hospitalizations, accidents or injuries you have had:

Less than 5 years ago: _____

More than 5 years ago: _____

Do you have any chronic, ongoing pain that you deal with on a regular basis, other than listed above? _____

Please explain: _____

Are you currently receiving any other type of medical treatment? _____ Please explain: _____

Please list any medication (vitamins, herbs or pharmaceutical) taken now or at regular intervals (include explanation of what medication is used to treat): _____

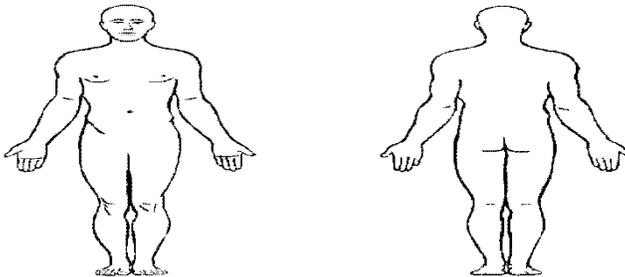
Are there any other health concerns you wish to discuss today? _____ If yes, please describe: _____

~~Please Sign and Complete Page 2 on the Reverse Side~~

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Please indicate where you experience pain on the drawing below



Are you currently experiencing any of the following conditions?

Flu or Cold: Y N Inflammation Y N Fever: Y N Infection: Y N Contagious Disease: Y N

Please check any of the following conditions below that currently affect you or that you have experienced in the last 5 years.

MUSCULOSKELETAL

- Fibromyalgia
- Spasms/Cramps
- Sprains/Strains
- Osteoporosis
- Postural Deviations
- Gout
- Osteoarthritis/Rheumatoid Arthritis
- TMJ
- Cysts
- Bursitis
- Plantar Fasciitis
- Tendonitis
- Torticollis
- Whiplash Syndrome
- Carpal Tunnel Syndrome
- Sciatica
- Thoracic Outlet Syndrome
- Headache
- Leg Pain
- Arm Pain/Shoulder Pain
- Low Back Pain
- Middle Back Pain
- Hip Pain
- Other _____

RESPIRATORY

- Pneumonia
- Sinusitis
- Asthma
- Trouble Breathing
- Dizziness
- Other _____

CIRCULATORY

- Anemia
- Hemophilia
- Hypertension
- Low Blood Pressure
- Raynaud's Disease
- Varicose Veins
- Heart Condition
- Blood Clots/Phlebitis
- Diabetes
- Other _____

DIGESTIVE

- Ulcers
- Irritable Bowel Syndrome
- Colitis
- Gallstones
- Hepatitis
- Crohn's Disease
- Diarrhea
- Gas/Bloating
- Indigestion
- Other _____

SKIN

- Fungal Infection
- Acne
- Impetigo
- Dermatitis/Eczema
- Psoriasis
- Open Wound or Sore
- Rashes
- Warts/Moles
- Athletes Foot

NERVOUS SYSTEM

- ALS
- Multiple Sclerosis
- Parkinson's Disease
- Bell's Palsy
- Neuritis
- Spinal Cord Injury
- Stroke
- Trigeminal Neuralgia
- Seizure Disorders
- Numbness/Tingling/Twitching
- Other _____

OTHER

- Insomnia
- Anxiety/Panic Attacks
- PMS
- Grief Process
- Cancer
- Substance Abuse
- Pregnancy; weeks: _____
- Chronic Fatigue
- HIV/AIDS
- Lupus
- Kidney Disease
- Bladder Infection
- Postoperative Situation
- Edema
- PTSD
- Sexual Assault
- Other _____

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose, treat, prevent, or cure disease. I further understand that massage therapy is not a substitute for medical attention or examination. By my signature, I consent to receive massage therapy and/or bodywork treatment. I take responsibility for alerting my practitioner to any physical, mental, or emotional changes that occur during my massage or at any time in the future. I release the massage/bodywork therapist, Medical Massage Specialties, and Ale B Brave LLC of any and all liability for any harm that may unintentionally occur during my treatment(s). I also understand that cancelled or missed appointments without 24 hours' notice will be charged in full for the price of the missed session. Medical Massage Specialties requires that a credit card or other accepted form of payment be kept on file to cover missed appointments. I understand that all massage services are non-refundable. I acknowledge that no refunds will be issued for services rendered or for missed appointments.

Print Name: _____ Parent/Guardian Signature (if minor): _____ Date: _____

Signature: _____ Date: _____