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: _____ Receive updates/newsletter from Medical Massage Specialties Y N

Occupation: _____

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: _____

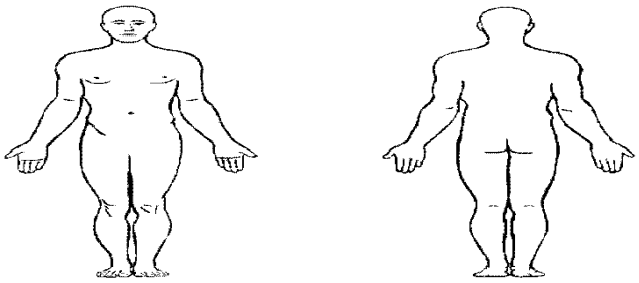
_____

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

Medical Massage Specialties

Therapeutic Massage in a Relaxing Atmosphere

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.

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

Signature: _____ Date: _____