

Massage Therapy – New Patient Information

Name: _____ Date: _____

Address: _____ Postal Code: _____

Telephone: (H) _____ (C) _____ (W) _____

Date of Birth: _____ Occupation: _____
YYYY / MM / DD

Activities: _____

Email: _____ Emergency Contact: _____ Ph: _____

Allergies: _____

Medications: _____

How did you hear about our office (please circle one):

Yellow Pages Sign Location Referral: _____

Medical Doctor: _____ Chiropractor: _____

What is your present complaint? _____

Do you know what caused this problem? _____

When do you experience the pain? (i.e. Sleep? Morning? After Activity?) _____

How long does it last? _____

Describe the pain (sharp, dull, numbness, tingling, aching, stabbing, etc.) _____

What relieves the pain? _____

Have you had any other injuries or surgery? If so, please describe and give date(s): _____

History of cancer recently or in the past five years? Yes/No _____

Describe: _____

Are you H.I.V.+? Yes/No

WOMEN ONLY: ARE YOU PREGNANT? Yes/No

DUE DATE: _____

PLEASE CHECK OFF ANY OF THE FOLLOWING THAT APPLY TO YOU:

- | | | | |
|---------------------------------|--------------------------|-------------------------------------|--------------------------|
| Rheumatoid Arthritis | <input type="checkbox"/> | Asthma | <input type="checkbox"/> |
| Fatigue | <input type="checkbox"/> | Heart Attack | <input type="checkbox"/> |
| Abdominal Pain | <input type="checkbox"/> | Stroke | <input type="checkbox"/> |
| Swelling of Joint | <input type="checkbox"/> | Skin Condition | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Morning Stiffness | <input type="checkbox"/> |
| Fractured Vertebrae | <input type="checkbox"/> | Crunching / Grinding | <input type="checkbox"/> |
| Spine tender to touch | <input type="checkbox"/> | Multiple Joint Pain | <input type="checkbox"/> |
| Respiratory / Urinary Infection | <input type="checkbox"/> | Numbness / Tingling | <input type="checkbox"/> |
| Bone Pain | <input type="checkbox"/> | Dizziness | <input type="checkbox"/> |
| Low Back Pain | <input type="checkbox"/> | Headaches | <input type="checkbox"/> |
| Varicose Veins | <input type="checkbox"/> | Fainting | <input type="checkbox"/> |
| Osteoporosis | <input type="checkbox"/> | Pins, Plates or Prosthesis | <input type="checkbox"/> |
| Brain Tumors | <input type="checkbox"/> | Weakness of Arm / Leg / Hand / Foot | <input type="checkbox"/> |

Please indicate any conditions not mentioned above: _____

I declare the information on this form to be true and correct in all respects. While rare, some patients may experience short-term aggravation of symptoms, muscle, and ligament sprains or strains, bruising or rib fractures as a result of massage therapy.

I acknowledge I have discussed, or have had the opportunity to discuss with my massage therapist the nature and purpose of massage therapist in general and my treatment as well as the content of this consent.

I consent to the massage therapy treatment offered or recommended to me by my massage therapist. I intend to consent to all my present and future massages.

Client Name (please print): _____

Client Signature: _____ Date: _____