



Medical Information Form

(Please Print)



Name _____
 Today's Date _____ Birth Date _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work _____ Cell _____
 Email _____

Medical Doctor's Name _____ Phone # _____
 Emergency Contact Name _____ Phone # _____

Referred by _____
 Occupation _____ Do you do a lot of: (check what apply)
 ___ standing ___ physical labor
 ___ sitting ___ repetitive movement
 Do you have physical problems possibly associated with the job? ___ yes ___ no

Please list any serious injuries, surgeries, supplements or medication:

Do you have chronic, ongoing pain? No ___ Yes ___ please describe _____

Are there activities that affect pain? _____

Exercise: Times/week _____ Activities _____

What is your primary reason for this appointment:

Injury ___ Relax ___ Headaches ___ Chronic Issue ___ Other _____

Have you received a therapeutic massage? No ___ Yes ___ How long since your last? _____

Check any of the following conditions, recent or chronic, that apply to you:

Musculoskeletal:

- ___ Osteoporosis
- ___ Arthritis
- ___ Fibromyalgia
- ___ Chronic Headaches
- ___ Whiplash
- ___ Cysts
- ___ Tendonitis
- ___ Chronic Pain:
 - ___ Neck
 - ___ Low Back
 - ___ Mid Back
 - ___ Upper Back
 - ___ Hip
 - ___ Arm
 - ___ Leg
 - ___ Shoulder
 - ___ Wrist/Hand
- ___ On computer more than an hour/day

Nervous System:

- ___ Dizziness
- ___ Spinal Cord Injury
- ___ Herniated Discs
- ___ Multiple Sclerosis
- ___ Parkinson's disease
- Other: _____

Circulatory:

- ___ Heart Problems _____
- ___ Blood Clots/Phlebitis
- ___ High/Low Blood Pressure
- ___ Stroke
- ___ Varicose Veins
- ___ Anemia
- ___ Peripheral Artery Disease
- Other: _____

Digestive:

- ___ Ulcers
- ___ Constipation
- ___ Diarrhea
- ___ IBS
- ___ Chronic Indigestion
- Other: _____

Other:

- ___ Breathing Problems
- ___ Asthma
- ___ Sinusitis
- ___ Diabetes
- ___ Cancer
- ___ HIV/AIDS
- ___ Poor sleep/Insomnia
- ___ High Stress
- ___ Anxiety/Panic Attacks
- ___ PREGNANT How far along _____
- Allergies _____
- Other: _____

I understand the rates for massages differ:
1 Hour Therapeutic Massage \$48
45 min. Therapeutic Massage \$40
30 min. Therapeutic Massage \$30
Chair Massages \$1/min. (\$60/hour + travel)
S.R.A. (Spinal Reflex Analysis) \$60 (allow 1 ½ hour time slot)

I understand Massage Therapists do not diagnose or prescribe drugs. I agree to alert my practitioner of any health changes that occur.

I understand that massage therapy is the manipulation of soft tissue, and different techniques will be used to not only address my symptoms but treat the dysfunction for my benefit. I understand and have correctly filled out this Medical Information Form to the best of my knowledge.

*****I understand that if I need to cancel an appointment I will do so before 8am the day of my appointment by calling 277-3166. Canceling within 2 hours of or no showing to my appointment will result in me (the client) being billed half the massage cost.*****

(Signature)

(Date)

****Thank you for coming in... enjoy!****

Feel free to mark specific areas you desire attention on...

