Replenish MASSAGE

personal information

_____
name date of birth

_____
address

_____
city state zip

_____
home phone cell phone

_____
email

_____
occupation

_____
referred by

_____
emergency contact name (relationship) phone

health history

Musculoskeletal
- ☐ Bone or joint disease
- ☐ Arthritis/Gout
- ☐ Lupus
- ☐ Migraines/Headaches
- ☐ Tendonitis/Bursitis
- ☐ Jaw Pain (TMJ)
- ☐ Spinal Problems
- ☐ Osteoporosis

Circulatory
- ☐ Heart Condition
- ☐ Blood Clots
- ☐ Lymphedema
- ☐ Phlebitis/Varicose Veins
- ☐ High/Low Blood Pressure
- ☐ Thrombosis/Embolism

Respiratory
- ☐ Breathing Difficulty/Asthma
- ☐ Allergies, specify:_____
- ☐ Sinus Problems
- ☐ Emphysema

Nervous System
- ☐ Shingles
- ☐ Pinched Nerve
- ☐ Paralysis
- ☐ Parkinson's Disease
- ☐ Numbness/Tingling
- ☐ Chronic Pain
- ☐ Multiple Sclerosis

Reproductive
- ☐ Pregnant, stage _____
- ☐ Prostate
- ☐ Ovarian/Menstrual Problems

Skin Allergies, specify: _____
- ☐ Rashes
- ☐ Athlete's Foot
- ☐ Cosmetic Surgery
- ☐ Herpes/Cold Sores

Digestive
- ☐ Bladder/Kidney Ailment
- ☐ Crohn's Disease
- ☐ Irritable Bowel Syndrome
- ☐ Colitis
- ☐ Ulcers

Psychological
- ☐ Anxiety/Stress Syndrome
- ☐ Depression

Other
- ☐ Cancer/Tumors
- ☐ Drug/Alcohol/Tobacco Use
- ☐ Dentures
- ☐ Diabetes
- ☐ Contact Lenses
- ☐ Hearing Aids

Any other medical condition(s) not listed: _____
Please explain any of the conditions that you have marked above
_____

_____

current health

Reason for initial visit _____
_____

Do you exercise regularly and/or participate in any sports? ☐ Y ☐ N
If yes, what kind of exercise/sports? _____

Do you perform any repetitive movement in your work, sports or hobby? If yes, describe _____ ☐ Y ☐ N

Do you sit for long hours at a workstation, computer or driving?
If yes, describe _____ ☐ Y ☐ N

Are you experiencing tension, stiffness, discomfort or pain? ☐ Y ☐ N
If yes, describe _____

Have you recently had an injury, surgery, or areas of inflammation?
If yes, describe _____ ☐ Y ☐ N

Do you have sensitive skin? ☐ Y ☐ N

Do you have any allergies to oils, lotions or ointments? ☐ Y ☐ N
If yes, please explain _____

List any medications you are currently taking _____
_____

List any known allergies _____
_____

massage experience

Have you had a professional massage before? ☐ Yes ☐ No

If yes, what types of massage have you had (swedish, shiatsu, deep tissue, etc.)? _____

How long have you been receiving massage therapy? _____

Frequency of massages?_____

*What are your goals for treatment?*_____
_____

client agreement

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

_____
signature date