

O'Brien

Therapeutic Massage

Personal Information

Name: _____ Gender: M F NB Other DOB: _____
Address: _____ City/State/Zip: _____
Day Phone: _____ Evening Phone: _____
Email: _____ Occupation: _____
Emergency Contact: _____ Phone: _____

Massage Experience

How did you hear about me?: _____

Have you ever had a professional massage before? Y / N

If yes, when was your last one?: _____ Frequency?: _____

What type of massage have you received? (deep tissue, Swedish, shiatsu, ROLFing, etc)

What results are you hoping to achieve with massage?

Are there any particular areas you are having problems with? Please explain:

Are there any areas you do NOT want to have worked on? _____

Health History

Please list any medications and/or supplements you are currently taking

Please list any illnesses, accidents, or injuries that are still affecting you

Please list any surgeries you have had and explain

Are you currently under the care of a doctor, or any medical practitioner? If yes, please explain

List any stress reduction exercises or activities you participate in, and frequency

Health History, Continued.

Please mark present (P), past (X), or Reoccurring (R) conditions:

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Atherosclerosis | <input type="checkbox"/> Athletes Foot/Fungal Infection |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Circulation Disorder |
| <input type="checkbox"/> Cold Sore/Herpes | <input type="checkbox"/> Decreased Sensation | <input type="checkbox"/> Diabetes, Type I or Type II |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Fibromyalgia or CFS | <input type="checkbox"/> Fractures | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Joint Disorder | <input type="checkbox"/> Lice or Scabies | <input type="checkbox"/> Lung or Breathing Problems |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Open Sores or Wounds | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Pregnant** | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Rash/Eczema | <input type="checkbox"/> Recent Accident or Injury | <input type="checkbox"/> Recent Surgery |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Scleroderma |
| <input type="checkbox"/> Spinal Problems | <input type="checkbox"/> Stroke or Blood Clots | <input type="checkbox"/> Swollen Glands |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Varicose Veins | |

Is there anything else about your health history your massage therapist should know before planning your massage session?

Informed Consent

I understand massage therapy is a health aid and does not take place of a physician's care. The practitioner can not diagnose illness, disease, or any other physical or mental disorder, and does not perscribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulation.

I have filled out this form to the best of my knowledge. I understand that it is my responsibility to inform the practitioner of any existing medical conditions I may have, and keep them informed of any changes in my health and medications in the future. I also acknowledge that if I do have a medical condition or specific symptoms, massage therapy may be contraindicated or problematic, and a referral from my physicial or health care provider may be required prior to treatment.

I hereby consent to receive massage therapy treatment from the practitioner.

Signature: _____ Date: _____