

REASON FOR MESSAGE

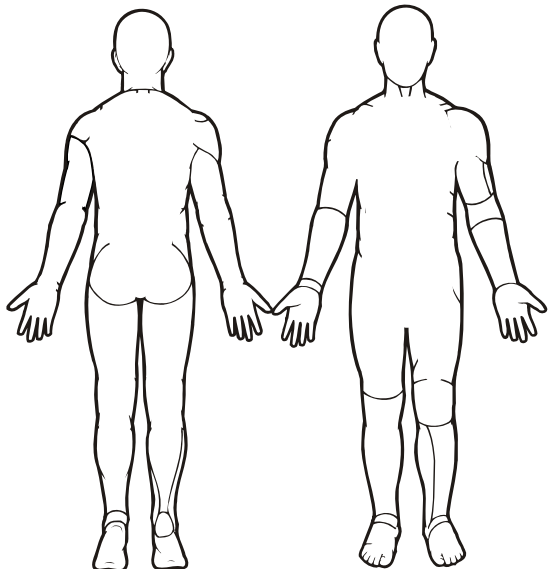
(Print Name) _____

(Today's Date) _____

Have you received body work/massage before? Yes No _____

Please describe any pain or discomfort you are having: _____

(Please Indicate the area of your pain)



When did your symptoms appear? _____

Have you had this condition in the past? Yes No

Is this condition getting progressively worse? Yes No

Is this condition? Constant Or Does it come & go

What type of treatment have you already received for this condition?

- Surgery Physical Therapy Chiropractic Care
- None Other _____

Check the activities that are painful to perform.

- Sitting Standing Walking Bending Lying Down

Have you ever had any of the following diseases/medical condition(s)?

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Heart Attack / Stroke | <input type="checkbox"/> Diabetes / Tuberculosis | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Heart Surg./Pacemaker | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Alcohol / Drug Abuse | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Ulcers / Colitis |
| <input type="checkbox"/> HIV+ / Aids | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Shingles | <input type="checkbox"/> Artificial Valves | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Emphysema/Glaucoma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Fainting/Seizures/Epilepsy | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Cancer | Other _____ |

Are you taking blood thinning medication? Yes No

List any surgeries you have had.

Date

For Women: Are you pregnant? Yes No Not sure If yes, how far along? _____

I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist prescribes neither medical treatment nor pharmaceuticals, nor performs any spinal manipulations. It has been made very clear to me that this massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Signature _____ Date _____

A 24 hour notice is required for massage cancellations. Appointments not canceled within 24 hours will be charged to the client.