Massage Therapy Patient Registration

Patient Information

Name_____ Date of Birth_____
Address_____City/St_____Zip_____
Home Phone_____ Work Phone_____
Occupation_____
Have you had a massage in the past? ☐Yes ☐ No When:_____
Reason for your visit today:_____
Is your visit related to: Auto Accident Employment Other Injury
If so, date of injury/Accident:_____
Claim Number:_____ Adjuster Phone:_____

Health and Medical Information

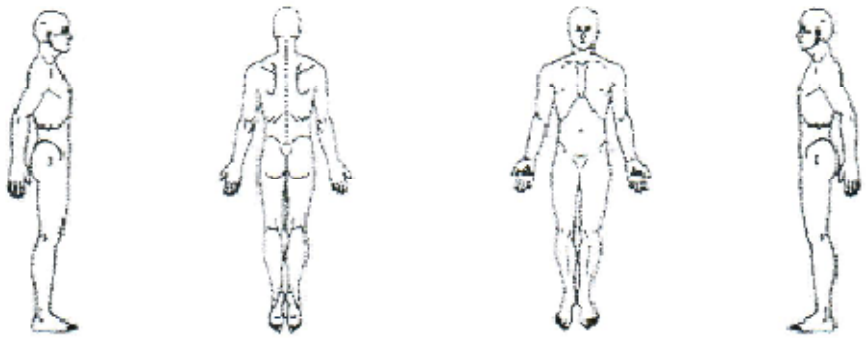
Are you currently pregnant: ☐Yes ☐ No
Are you currently taking any medications? ☐Yes ☐ No
If yes, please list names and reason for medications_____
_____
Are you currently seeing a healthcare professional? ☐ Yes ☐ No
Primary Physician:_____Phone:_____
Address:_____Zip:_____
If yes, please list names and reason/treatment_____
_____
Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.

- ☐ Arthritis
- ☐ Diabetes
- ☐ Blood clots
- ☐ Broken/dislocated bones
- ☐ Bruise easily
- ☐ Cancer
- ☐ Chronic pain
- ☐ Constipation/diarrhea
- ☐ Auto-immune condition*
- ☐ Hepatitis (A, B, C, other)
- ☐ Scoliosis
- ☐ Stroke
- ☐ Whiplash
- ☐ Depression, panic disorder, psych condition
- ☐ TMJ disorder
- ☐ Diverticulitis
- ☐ Headaches
- ☐ Heart conditions
- ☐ Back problems
- ☐ High blood pressure
- ☐ Insomnia
- ☐ Muscle strain/sprain
- ☐ Skin conditions
- ☐ Seizures
- ☐ Surgery
- ☐ Chemical dependency (alcohol, drugs)

(*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

If any of the above needs to be detailed or if there is anything else to share please do so:_____
_____

Do you have any of the following today: _____ skin rash _____ cold/flu _____ open cuts
_____ severe pain _____ anything contagious _____ injuries/bruises
Do you have any allergies to: _____ Medications _____ Foods (nuts, etc.)
_____ Environmental allergens (dust, pollen, fragrances)
Please indicate with an (X), if any, the areas in which you are feeling discomfort:



The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to: need to move or change position, sighing, yawning, change in breathing, stomach gurgling, emotional feelings and/or expression, movement of intestinal gas, energy shifts falling asleep, memories.

<u>Please read the following information and sign below:</u>

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all the questions pertaining to medical conditions truthfully.

Signature: _____ Date: _____