

MESSAGE CLIENT INFORMATION

Today's Date _____

Last Name _____ First Name _____ Middle Initial _____

Address _____
street city state zip

Date of Birth _____ Age _____ Sex M F
mm/dd/yyyy

Home Phone _____ Cell Phone _____

Email _____

Employer _____ Work Phone _____

GENERAL & MEDICAL INFORMATION

Y N Have you ever had a professional massage? If yes, how often? _____

Y N Are you pregnant? If yes, how far along are you? _____

Y N Are you sensitive to touch/pressure in any area? _____

Y N Are you allergic or sensitive to any oils (essentials oils, nut oils, scents)? If yes, please list: _____

List of surgeries (type and date): _____

CURRENT CONDITION

What is your present complaint? _____

Date pain began: _____ On a scale from 1-10, 10=highest, rate your level of pain _____/10

How did your symptoms begin? _____

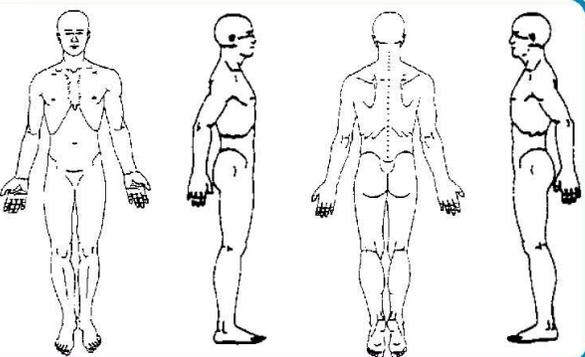
What have you done for relief? _____

What aggravates your condition? _____

Is the condition getting better/worse? _____ Are you taking pain relief medication? _____

How long have you been taking medication for pain relief? _____

Please mark on the diagram where you have pain, tension or other discomfort





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MEDICAL HISTORY

Check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Skin Condition-rash, warts, hives, skin cancer, other _____ |
| <input type="checkbox"/> Numbness/Tingling, Sciatica | <input type="checkbox"/> Lymphatic condition-swollen gland, nasal congestion, lymph edema |
| <input type="checkbox"/> Tendonitis, Bursitis | <input type="checkbox"/> Joint problems/stiffness-arthritis – where? _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bone condition-osteoporosis, fracture, other _____ |
| <input type="checkbox"/> Circulatory Condition-high blood pressure, varicose veins, blood clots | <input type="checkbox"/> Recent injury or accident-whiplash, sprain, bruise, other _____ |

1. Have you ever had any injuries (ankle, knee, hip, back, shoulder, etc.)? If yes, please explain: _____

2. Have you ever had any surgeries? If yes, please explain: _____

3. Has a medical doctor ever diagnosed you with a chronic disease, such as coronary heart disease, hypertension, high cholesterol or diabetes? If yes, please explain: _____

4. Are you currently taking any medication for conditions other than pain relief? If yes, please explain: _____

GENERAL LIFESTYLE INFORMATION

1. What is your current occupation? _____

2. Does your occupation require extended periods of sitting? _____

3. Does your occupation require extended periods of repetitive movements? If yes, please explain: _____

4. Does your occupation require you to wear shoes with a heel (dress shoes)? _____

5. Does your occupation cause you anxiety (mental stress)? _____

6. Do you partake in any recreational activities (golf, tennis, skiing, etc.)? If yes, please explain: _____

7. Do you have any hobbies (reading, gardening, working on cars, etc.)? If yes, please explain: _____

8. What are your goals for treatment? _____



Informed Consent Agreement

I understand that the massage given to me by the massage therapists associated with Premiere Spine & Sport is for the purpose of reducing pain, reducing stress, relieving muscle tension, increasing range of motion, and improving circulation.

I understand that the massage therapist does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy.

I understand that massage therapy is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have.

If at any point during the massage I am uncomfortable or uneasy with the procedures being administered and/or if I experience pain, I understand that it is my responsibility to immediately inform the massage therapist, so that the strokes and pressure can be adjusted to a level of comfort, or the massage can be terminated.

I have informed the massage therapist of all my known physical conditions, medical conditions and current medications, and I will keep the massage therapist updated on any changes for future sessions.

Client Signature

Date

Client Name - Print