Date_____/_____/_____

Personal Information

Name _____ Date of Birth _____

Phone (Cell) _____ Phone (Home) _____

E-mail _____

Address _____ City State Zip

Occupation _____

Marital Status _____

Emergency Contact Name _____ Emergency Contact Phone _____

Goals in receiving massage _____

- **Do you exercise/participate in sports? Y / N**

if Yes, what kind of exercise/sports & how often? _____

- **Do you perform repetitive movement at work? Y / N**

if Yes, describe _____

- **Do you sit for long hours at work, home, driving? Y / N**

if Yes, describe _____

- **Did you have any injury, surgery in the past? Y / N**

if Yes, describe _____

Medication	**Treatment of**
Medication	**Treatment of**
Medication	**Treatment of**

History / Current Condition

Please check those that apply

Musculoskeletal
__ Bone or joint disease
__ Arthritis
__ Jaw Pain (TMJ)
__ Spinal Problem
__ Osteoporosis
__ Fibromyalgia

Circulatory
__ Heart Condition
__ Stroke
__ Phlebitis/Varicose Veins
__ Blood Clots
__ High Blood Pressure
__ Low Blood Pressure
__ Anemia
__ Thrombosis/Embolism

Respiratory
__ Asthma / Breathing difficulty
__ Emphysema
__ Sinus Problem
__ Allergies
specify _____

Nervous System
__ Tension Headache
__ Migraine Headache
__ Numbness / Tingling
__ Paralysis
__ Multiple Sclerosis
__ Parkinson's Disease
__ Seizure Disorder

Reproductive
__ Pregnant
__ Endometriosis
__ Ovarian/Menstrual Problem
__ Prostate

Digestive
__ Irritable Bowel Syndrome
__ Gallstones
__ Ulcers
__ Cirrhosis

Psychological
__ Anxiety
__ Depression

Skin
__ Sensitivities
__ Cosmetic Surgery

Other
__ Diabetes
__ Cancer
__ Autoimmune Disorder

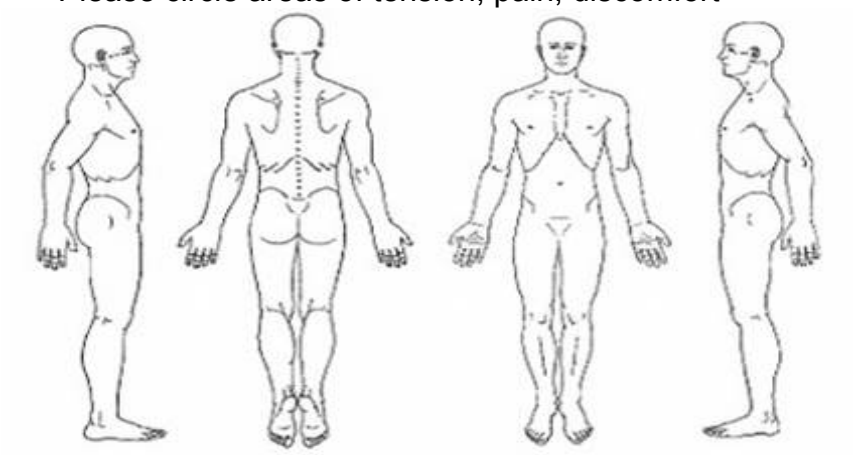
Please write other medical conditions not listed _____

Massage Experience

Have you had a massage before? Y / N

if Yes, what type? (Swedish, Deep Tissue, Shiatsu, etc) _____

Please circle areas of tension, pain, discomfort



What makes the pain better?

What makes the pain worse?