# MASSAGE THERAPY FORM

The information request below will assist us in treating you safely. Feel Free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

SURNAME: _____ FIRST NAME: _____

ADDRESS: _____

PHONE #_____ ALTERNATE PHONE # _____

OCCUPATION: _____ DOB:_____

HAVE YOU RECEIVED MASSAGE THERAPY BEFORE? □ YES □NO

DID A HEALTH CARE PRACTITIONER REFER YOU FOR MASSAGE THERAPY? □ YES □ NO

IF YES, PLEASE PROVIDE THEIR NAME AND ADDRESS:_____

_____

PLEASE INDICATE ANY CONDITIONS YOU ARE EXPERIENCING OR HAVE EXPERIENCED:

**CARDIOVASCULAR:**

□ HIGH BLOOD PRESSURE

□LOW BLOOD PRESSURE

□ CHRONIC CONGESTIVE HEART FAILURE

□HEART ATTACK

□PHLEBITIS/VARICOSE VEINS

□STROKE/CVA

□PACEMAKER OR SIMILAR DEVICE

□HEART DISEASE

IS THERE A FAMILY HISTORY OF ANY OF THE ABOVE? □YES □NO

**RESPIRATORY**

□CHRONIC COUGH

□SHORTNESS OF BREATH

□BRONCHITIS

□ASHTMA

□EMPHYSEMA

IS THERE A FAMILY HISTORY OF ANY OF THE ABOVE?

□YES □NO

**INFECTIONS**

□ HEPATITIS

□SKIN CONDITIONS

□TB

□HIV

□HERPES

**OTHER CONDITIONS**

□ LOSS OF SENSATION, WHERE?

_____

□DIABETES,

ONSET: _____

ALLERGIES/HYPERSENSITIVITY, TO

WHAT?_____

TYPE OF REACTION:_____

□EPILEPSY

□CANCER, WHERE?

_____

□SKIN CONDITIONS, WHAT?

_____

□ARTHRITIS

IS THERE A FAMILY HISTORY OF ARTHRITIS?

□YES □NO

**HEAD/NECK**

□HISTORY OF HEADACHES

□HISTORY OF MIGRANES

□VISION PROBLEMS

□VISION LOSS

□EAR PROBLEMS

□HEARING LOSS

**WOMEN**

□ PREGNANT, DUE:_____

□GYNAECOLOGICAL CONDITIONS,

WHAT _____

OVERALL, HOW IS YOUR GENERAL HEALTH?

_____

PRIMARY CARE PHYSICIAN:

_____

ADDRESS:

**DATE OF INITIAL HEATH HISTORY:**

_____

UPDATE 1:_____

UPDATE 2: _____

UPDATE 3: _____

UPDATE 4: _____

| | |
|---|---|
| CURRENT MEDICATIONS:<br>_____<br>CONDITION IT TREATS:<br>_____<br>ARE YOU CURRENTLY RECEIVING TREATMENT FROM ANOTHER HEALTH PROFESSION? □YES □NO<br>IF YES, FOR WHAT? _____<br>_____<br>SURGERY – DATE: _____<br>NATURE: _____<br>INJURY – DATE: _____<br>NATURE: _____ | DO YOUHAVE ANY OTHER MEDICAL CONDITIONS? (E.G. DIGESTIVE CONDITIONS, HAEMOPHILIA, OSTEOPOROSIS, MENTAL ILLNESS) □ YES □ NO<br>WHAT? _____<br>DO YOU HAVE ANY INTERNAL PINS, WIRES, ARTIFICIAL JOINTS OR SPECIAL EQUIPMENT? □YES □NO<br>WHAT? _____<br>WHERE? _____<br>WHAT IS THE REASON YOU ARE SEEKING MASSAGE THERAPY?<br>_____<br>PLEASE INCLUDE THE LOCATION OF ANY TISSUE OR JOING DISCOMFORT.<br>_____<br>_____ |

**AUTHORIZATION AND CONSENT**

IT IS MY CHOICE TO RECEIVE MASSAGE THERAPY. I REALIZE THAT THE TREATMENT IS BEING GIVEN FOR THE WELL BEING OF MY BODY AND MIND. THIS INCLUDES STRESS REDUCTION, RELIEF FROM MUSCULAR TENSION, SPASM OR PAIN OR FOR INCREASING CIRCULATION OR ENERGY FLOW. I AGREE TO COMMUNICATE WITH MY PRACTITIONER ANY TIME I FEEL LIKE MY WELL BEING IS BEING COMPROMISED.

I UNDERSTAND THAT MASSAGE PRACTITIONERS DO NOT DIAGNOSE ILLNESS, DISEASE, OR ANY PHYSICAL OR MENTAL DISORDER; NOR DO THEY PRESCRIBE MEDICAL TREATMENT, PHARMACEUTICALS, OR PERFORM SPINAL THRUST MANIPULATIONS. I ACKNOWLEDGE THAT MASSAGE IS NOT A SUBSTITUTE FOR MEDICAL EXAMINATION OR DIAGNOSIS, AND THAT IT IS RECOMMENED THAT I SEE A PRIMARY HEALTH CARE PROVIDER FOR THAT SERVICE.

I HAVE STATED ALL MEDICAL CONDITIONS THAT I AM AWARE OF AND WILL UPDATE THE MASSAGE PRACTITIONER OF ANY CHANGES IN MY HEALTH STATUS.

SIGNATURE: _____ DATE: _____