



1000 South Fifth Street, Easley SC 29640 864-306-0336

Date \_\_\_\_\_

Print Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

How would you prefer to be contacted with promotions & appointments reminders?

Email \_\_\_\_\_ Phone \_\_\_\_\_ Neither \_\_\_\_\_

Have you had a massage before? Yes / No If so, when was your last massage? \_\_\_\_\_

What are your reasons for being here? (Circle any that apply)

Health and wellness    relaxation    stress    pain    injury    headache    pregnancy

Occupation: \_\_\_\_\_ DOB \_\_\_\_\_ Emergency Contact: \_\_\_\_\_

Emergency Contact Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Health History**

**\*\* CHECK  by all conditions that you currently have and  all previous conditions \*\***

- |   |   |   |  |  |
|---|---|---|--|--|
| <input type="checkbox"/> AIDS           | <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Fibromyalgia      | <input type="checkbox"/> Shingles        |
| <input type="checkbox"/> Hernia/Rupture | <input type="checkbox"/> Hay fever          | <input type="checkbox"/> Broken bones           | <input type="checkbox"/> Lymph congestion  | <input type="checkbox"/> Sciatica        |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> HIV                | <input type="checkbox"/> Lupus                  | <input type="checkbox"/> Osteoporosis      | <input type="checkbox"/> Blood clots     |
| <input type="checkbox"/> Stroke         | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Insomnia               | <input type="checkbox"/> Migraines         | <input type="checkbox"/> Spinal injuries |
| <input type="checkbox"/> Neck pain      | <input type="checkbox"/> Blood pressure H/L | <input type="checkbox"/> Headaches              | <input type="checkbox"/> Osteoarthritis    | <input type="checkbox"/> Panic attacks   |
| <input type="checkbox"/> Infections     | <input type="checkbox"/> Thyroid issues     | <input type="checkbox"/> Vertigo                | <input type="checkbox"/> Varicose veins    | <input type="checkbox"/> Major fall      |
| <input type="checkbox"/> Spastic colon  | <input type="checkbox"/> Epstein-Barr       | <input type="checkbox"/> Chemical sensitivities | <input type="checkbox"/> Sleeping disorder | <input type="checkbox"/> Irritable bowel |

Please list all medical problems currently being treated by a medical doctor:

\_\_\_\_\_  
\_\_\_\_\_

List all medications: \_\_\_\_\_

Please make notes here of anything we should know: \_\_\_\_\_

\_\_\_\_\_

List all Allergies (scents, nuts, etc.) \_\_\_\_\_

Surgeries, Accidents, or Illnesses: \_\_\_\_\_

If you have ever experienced any of the following in the past or currently, explain.

Pain, numbness, tingling, swelling, fatigue, etc.: \_\_\_\_\_

**Check the box that best describes each of these concerns below:**

	Frequently & Severe	Frequently	Rarely	None
Migraines				
Headaches				
Neck pain & Tightness				
Diarrhea				
Blurred vision				
Acid reflux				
Tender areas				
Open cuts/sores				
Skin allergies				
Chest pains				
Varicose veins				
High blood pressure				
Low blood pressure				
Swelling in feet/ankles				
Leg cramps				
Phlebitis/thrombosis				
Difficulty relaxing				
Difficulty sleeping				
Sinus problems				
Easily out of breath				

**Health & Wellness Information**

On a scale of 1-10 (10 being high, 1 being low) Please rate the Following:

Amount of negativity in your life \_\_\_\_\_ Personal stress \_\_\_\_\_

How many glasses of water do you drink each day? \_\_\_\_\_

**Please Circle One:**

Have you ever had motion sickness? Yes / No

Left (L) or Right (R) Hand Dominant?

Introvert (not talkative) or Extrovert (very talkative)?

Are you a primary caregiver of someone else? Yes / No

Have you recently lost a job or changed careers? Yes / No

Have you had a major relationship change? Yes / No

Have you had ANY incident happen EVER over which you felt you had no control? Yes / No

If yes, Explain: \_\_\_\_\_

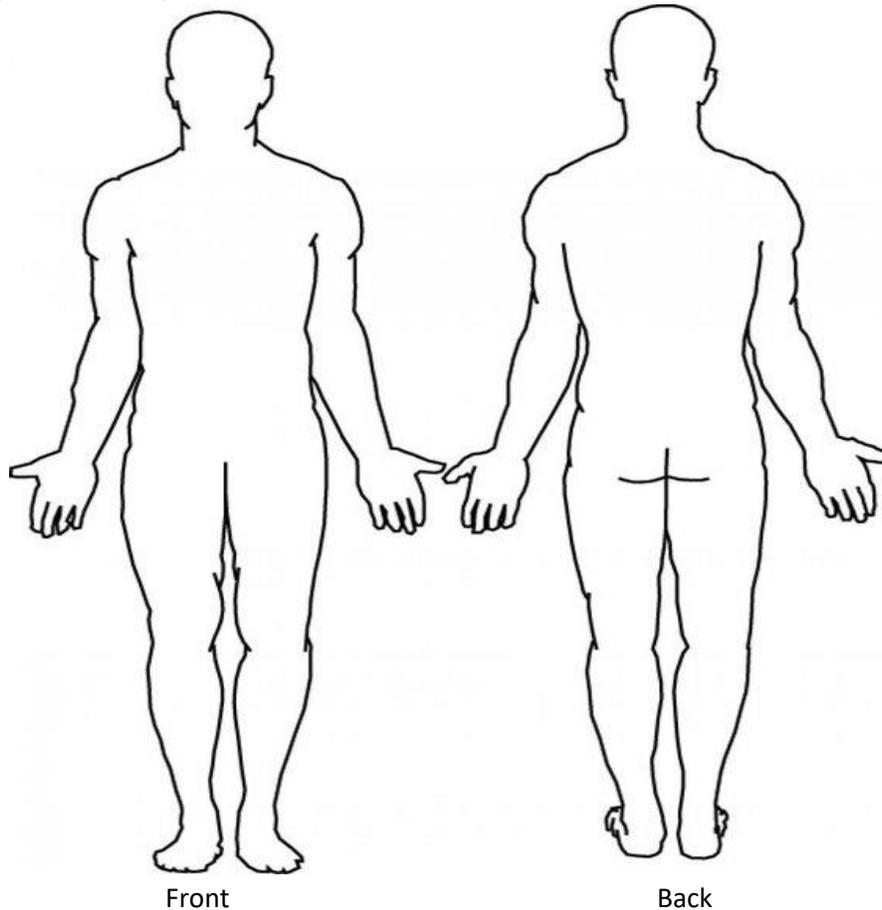
What movements cause or aggravate your pain? Please **check all that apply**.

\_\_\_ Standing \_\_\_ Sitting \_\_\_ Driving \_\_\_ Bending \_\_\_ Stooping \_\_\_ Kneeling \_\_\_ Lifting

\_\_\_ Other (Please Explain) \_\_\_\_\_

On the figures below please **Shade** in any areas of muscle or joint pain/stiffness

**Circle** the areas where you have had pain for some time.



Please **CIRCLE** what your pain level is right now? **0= No pain to 10= Worst pain of your life.**

0 1 2 3 4 5 6 7 8 9 10

## Disclaimer and Release of Liability

I, \_\_\_\_\_, understand and agree to the following statements:  
( Please Print Name)

- Information provided to me, written or stated, by ETM is for Informational and educational purposes only. This information is not meant to substitute for the advice provided by my medical provider and/or personal physician; or any other medical professional.

- I understand and voluntarily accept any risk associated with massage.

- I understand that if I have, or suspect that I have, a medical problem I will promptly contact my health care provider. It is my responsibility to immediately inform a therapist of any changes, pre-existing conditions, limitations, or specific sensitivities. I must personally make sure to update my client information file.

- Information and suggestions regarding dietary supplements have not yet been evaluated by the Food and Drug Administration and are not intended to diagnose, treat, care, or prevent any disease. I absolve and hold harmless ETM ( to include independent contractors and employees) from any liability/responsibility

- I release ETM from any and all loss and damage to myself and those that I bring into association with ETM. This serves as my consent to release my medical records to ETM if we request them.

- ETM/Easley Therapeutic Massage & Wellness Center is also referred to as ETM, Easley Therapeutic Massage and/or Wendy Law (May include independent contractors and employees) and can be understood to be the same sometimes. This release applies to all of the previously named.

- It is my responsibility to immediately notify the therapist if I have any discomfort or have concern during the session.

- Appointments/ massages must be cancelled 24 hours prior to appointment time.

- No show Appointments will incur full service fee, same day cancellations will incur a \$35 fee.

Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_\_\_