

**Massage Therapy – New Patient Information**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: (h) \_\_\_\_\_ (C) \_\_\_\_\_ (w) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Activities: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

How did you hear about our office (please circle one):

Yellow Pages      Sign      Location      Referral: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_ Chiropractor: \_\_\_\_\_

What is your presenting complaint? \_\_\_\_\_

\_\_\_\_\_

Do you know what caused this problem? \_\_\_\_\_

\_\_\_\_\_

When do you experience the pain? (i.e. Sleep? Morning? After activity?) \_\_\_\_\_

\_\_\_\_\_

How long does it last? \_\_\_\_\_

Describe the pain (sharp, dull, numbness, tingling, aching, stabbing etc.): \_\_\_\_\_

\_\_\_\_\_

What relieves the pain? \_\_\_\_\_

Have you had any other injuries or surgery? If so, please describe and give date(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

History of cancer recently or in the past five years? Yes/No \_\_\_\_\_

Describe: \_\_\_\_\_

Are you H.I.V.+? Yes/No

WOMEN ONLY: ARE YOU PREGNANT? Yes/No      DUE DATE: \_\_\_\_\_

**PLEASE CHECK OFF ANY OF THE FOLLOWING THAT APPLY TO YOU:**

Rheumatoid Arthritis	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Swelling of Joint	<input type="checkbox"/>	Skin condition	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Morning stiffness	<input type="checkbox"/>
Fractured vertebrae	<input type="checkbox"/>	Crunching/ grinding	<input type="checkbox"/>
Spine tender to touch	<input type="checkbox"/>	Multiple joint pain	<input type="checkbox"/>
Respiratory/ Urinary infection	<input type="checkbox"/>	Numbness/ tingling	<input type="checkbox"/>
Bone pain	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>
Low back pain	<input type="checkbox"/>	Headaches	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	Fainting	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	Pins, Plates or Prosthesis	<input type="checkbox"/>
Brain tumors	<input type="checkbox"/>	Weakness of arm/ leg/hand foot	<input type="checkbox"/>

Please indicate any conditions not mentioned above: \_\_\_\_\_

**I declare the information on this form to be true and correct in all respects. While rare, some patients may experience short term aggravation of symptoms, muscle and ligament sprains or strains, bruising or rib fractures as a result of massage therapy.**

**I acknowledge I have discussed, or have had the opportunity to discuss with my massage therapist the nature and purpose of massage therapy in general and my treatment as well as the contents of this consent.**

**I consent to the massage therapy treatment offered or recommended to me by my massage therapist. I intend this consent to all my present and future massages.**

Client Name (please print): \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_