Jared Green Therapeutics

Massage & Yoga Health History Form

Name: _____ Date of Birth: ____/____/____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ _____ _____ Email: _____

☐ Please add me to your last-minute contact list for discounts and promotions via email.

How did you hear about me?

☐ Gift Certificate	☐ Outside Sign/Flyer	☐ Doctor/ Chiropractor	☐ Friend/Family: _____	☐ Google	☐ Yelp!	☐ Other: _____

Current Occupation: _____ Previous Occupation: _____

Current Exercise/Sports: _____ Previous Exercise/Sports: _____

Are you pregnant? How many weeks? _____

If so, any complications? _____

Rate your current stress level: 1 2 3 4 5

☐ Play(ed) a musical instrument? Which? _____

☐ Stand still for 3+ hours a day?

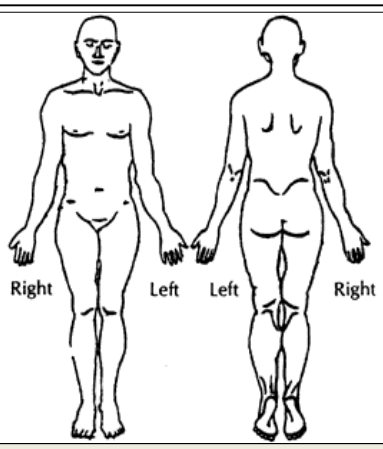
☐ Daily computer/desk use? Hours per day: _____

☐ Drive 2+ hours a day?

Reason(s) for todays appointment?

☐ Relaxation	☐ Stress/ Anxiety	☐ Car/Bike Accident	☐ Headaches/ Migraines	☐ Sports Injury	☐ Pre/Post Natal	☐ Post Surgery	☐ Other: _____
☐ Jaw Pain	☐ Neck Pain	☐ Shoulder Pain	☐ Back Pain	☐ Hip Pain	☐ Knee Pain	☐ Ankle/Foot Pain	☐ Wrist/Hand Pain

Describe all injuries and surgeries: _____



Circle areas of pain
Put an X where you feel muscle tension
Put an N where you feel numbness/tingling

Have you ever been in an automobile/bike accident? Were you hurt?

_____

_____

What areas of your body tighten up when you're active or stressed?

_____

_____

How would you describe your posture? Notes: _____

☐ Fine ☐ Not Great ☐ Horrible _____

Please turn over and fill out Page 2

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☐ Check this box if this is your first massage.

If no, when was your most recent massage? _____

Any allergies, such as nut-based oils? Which?

_____

_____

Have a tendency to bruise easily? ☐ Yes ☐ No

Take blood-thinning medication? ☐ Yes ☐ No

Anything else you want me to know? Do you have a preference with music? Aversion to essential oils?

_____

_____

_____

_____

_____

_____

Please check off any of the following health conditions and note whether current or past:

☐ Arthritis: _____	☐ Heart Disease: _____	☐ Pins/Staples: _____
☐ Asthma: _____	☐ High Blood Pressure: _____	☐ Seizures: _____
☐ Bursitis: _____	☐ Infections (current): _____	☐ Severe Menstrual Cramps:
☐ Cancer: _____	☐ Kidney Issue: _____	_____
☐ Concussion: _____	☐ Liver Issue: _____	☐ Sinus Pressure: _____
☐ Diabetes: _____	☐ Low Blood Pressure: _____	☐ Skin Issue: _____
☐ Digestive Disorders: _____	☐ Migraines: _____	☐ Vertebral Issue: _____
☐ Dizziness: _____	☐ Nausea: _____	☐ Whiplash: _____
☐ Headaches: _____	☐ Pacemaker: _____	☐ Other: _____

Please list all current medications and supplements: _____

_____

Informed consent for massage therapy:

I understand that the massage given to me by Jared G. is for the purpose of: stress reduction, pain reduction, relief from muscle tension, increasing circulation, or specific reasons stated on this form.

I understand that Jared G. 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.

I have stated all my known physical conditions and medications, and I will keep Jared G. updated on any changes.

By signing I am acknowledging that I have filled out this form to the best of my ability and that the information I provided is accurate.

_____ Signature

_____ Date