Love My Healthy Life

Name: First ______________________________ Last ________________________________

e-mail: ______________________@____________________ Cell: ____________________

Address ____ City, ZIP ____________________

Phone Daytime ______________ Home ____

Birth Date ____________________ Occupation ______________________________________

Referred By ____

Emergency Contact: Name ____________________________ Phone ______________________

Physician: Name ____

Massage Information

First professional massage: ❑ Yes ❑ No; how frequently do you have massage: ______________

Medical Information

List accidents/injuries, hospitalizations, and surgeries: when they occurred and treatment received

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Any lingering effects from the above or do you feel you have recovered?

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Chronic, ongoing pain? ❑ No ❑ Yes, please describe and any care or treatment you receive

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Do activities affect the pain? ❑ No ❑ Yes, please describe

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Are you currently being treated medically or taking prescribed drugs? ❑ No ❑ Yes, please describe

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Please list all over the counter, supplements, and/or herbs taken and why

History (helps determine treatment options)

Musculoskeletal

- ❑ Osteoporosis
- ❑ Arthritis
- ❑ Hypothyroidism
- ❑ Fibromyalgia
- ❑ Chronic Fatigue
- ❑ Gout in ________________
- ❑ Bursitis
- ❑ Plantar Fascitis
- ❑ Cysts/Lipomas
- ❑ TMJ
- ❑ Chronic Headaches
- ❑ Tendonitis
- ❑ Whiplash
- ❑ Strains/Sprains
- ❑ Chronic pain in:
  - ❑ Neck
  - ❑ Low-back
  - ❑ Mid-back
  - ❑ Upper-back
  - ❑ Hip
  - ❑ Arm
  - ❑ Leg
  - ❑ Shoulder
  - ❑ Wrist/Hand
- ❑ On computer more than 2 hrs/day. No. of hrs: ______

Respiratory

- ❑ Pneumonia
- ❑ Asthma
- ❑ Breathing Problems
- ❑ Sinusitis
- ❑ Other: ________________

Digestive

- ❑ Ulcers
- ❑ Colitis
- ❑ IBS
- ❑ Crone's disease
- ❑ Gluten Intolerance
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gallstones
- ❑ Gas/Bloating
- ❑ Chronic Indigestion

Circulatory

- ❑ Heart problems: __________
- ❑ Stroke
- ❑ Palpitations
- ❑ Mitral valve prolapse
- ❑ Anemia
- ❑ Hemophilia
- ❑ Hypertension
- ❑ Low Blood Pressure
- ❑ Peripheral Artery Disease
- ❑ Raynaud's Disease
- ❑ Varicose veins
- ❑ Blood clots/Phlebitis

Skin

- ❑ Fungal infections
- ❑ Athlete's Foot
- ❑ Impetigo
- ❑ Eczema/Dermatitis
- ❑ Psoriasis
- ❑ Easily irritated skin
- ❑ Other: ________________

Nervous System

- ❑ Dizziness
- ❑ ALS
- ❑ Multiple Sclerosis
- ❑ Parkinson's disease
- ❑ Bell's Palsy
- ❑ Neuritis
- ❑ Spinal cord injury
- ❑ Trigeminal Neuralgia
- ❑ Seizures/Epilepsy

Other

- ❑ Diabetes
- ❑ Pregnancy
- ❑ Cancer
- ❑ Kidney disease
- ❑ Hepatitis
- ❑ HIV/AIDS
- ❑ Lupus
- ❑ Postoperative: ____________
- ❑ Cystitis
- ❑ High stress
- ❑ Grieving
- ❑ Anxiety/Panic Attacks
- ❑ Bipolar syndrome
- ❑ PMS/Menopause difficulties
- ❑ Poor sleep/Insomnia
- ❑ Allergies affecting:
  - ❑ Facial skin
  - ❑ Body skin
  - ❑ Nose/Sinuses
  - ❑ Eyes
  - ❑ Stomach/Gut
- ❑ Orthopedic pins or plates
- ❑ Other: ________________

Exercise

Time/day-week: ________________ Activities: ________________________________

The above information is accurate. I understand that Massage Therapists do not diagnose disease or prescribe drugs and that they are not a substitute for medical care. I agree to alert my practitioner of any physical/emotional changes as they occur. I also understand that a missed appointment might incur charges that I must pay. Please note: a minimum of 24h notice is required.

Gratuities are not included into the service fee therefore it would be greatly appreciated, thank you.

Signature ________________________________ Date ________________________