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Healing therapies guided by your own inner wisdom

MASSAGE THERAPY PATIENT INFORMATION FORM
(Non-Insurance)

Date:_______/_______/________

Patient Name:———————————————————- Date of Birth _______/______/______ Age _________
Female ______ Male ______ Single ______ Married/Partnered ______ Divorced ________ Widowed ______
Occupation __________________________ (so I know what muscles you use) Employer ________________________
Address ____ Home Phone ___________________________________
____ Work Phone ____________________________________
____ Cell Phone ____________________________________
Zip _________________ E-mail Address (Home) ____
E-mail Address (Work)____
Have you received therapeutic massage therapy before? _____ Yes ______ No _____ Unsure

Reason for seeking massage today:

Just to relax, no problems ___ Pain/tenderness _____ (where) ____

Stiffness ___ (where) ____ Numbness/tingling ___ (where) ____________

Taking any medications or pain relievers today? ______ (If so, what) ____

____

Are you currently experiencing any of the following conditions:

High Blood Pressure (140/90 or greater, uncontrolled) ________ Cold/flu ____ Fever ___

Infection ___ (where) ________________________ (If you have any of these above, massage is not indicated at this time)

Auto-immune conditions? ___ If so, what? ____ Allergies ______

(If so, what) ______________________________________ Do you have diabetes/low blood sugar? _____ If yes, have you

eaten w/in the past hour? _______ Do you have a history of heart problems? ____ Are you pregnant? ____ If so, how

many weeks? ____ Any chronic diseases or problems ? _______________________ Accidents or surgeries? _____________
If yes, elaborate here____

____

Is there any other health issue not mentioned that you are dealing with? (If yes, what?)
____

PLEASE READ AND SIGN THE FOLLOWING:
I understand that the above information is correct to the best of my knowledge. I acknowledge that manual therapy is not a substitute for medical diagnosis and treatment. I understand that manual therapy treatments are my financial responsibility and I agree to pay for these services at the time of treatment unless other arrangements have been made in advance.

Signature: ____ Date: ________________