CONFIDENTIAL *CLIENT* INFORMATION AND HEALTH HISTORY FOR MEDICAL MASSAGE

First Name: _____ M.I._____ Last Name:_____

Address:_____Apt#_____ City:_____State: _____ Zip: _____

Phone(h): _____(C)_____Date of Birth:_____Single:_____ Married:_____

Employer: _____ Occupation: _____

Emergency contact:_____ Phone:_____ Relationship:_____

Policy or Claim #(*For Auto Accident*)_____

Name of your Claims Adjuster:_____Phone:_____ Ext:_____

Who Referred You :_____Your e-mail:_____ _____

Is this your first professional massage? _____ If no, how frequently do you get a massage? _____

What do you hope to accomplish from today's massage? _____

Are you aware of any tension holding spots in your body? _____ If yes, location(s) _____

Describe any surgeries, hospitalizations, accidents or injuries you have had:_____

Date of injury:_____ Date Unable to work:_____ Dates you were hospitalized:_____

What kind of care did you receive for your accidents or injuries? _____

Do you feel that you have recovered from these events? _____ Please explain: _____

Do you have any chronic, ongoing pain that you deal with on a regular basis? [ ] Yes [ ] No When did it begin?_____

Please explain: _____

On scale of 1-5 with 1 being minor 5 being worse how bad is the pain today_____? Is the pain felt anywhere else?_____

Describe what activities cause this pain and/or make it worse:_____ What makes it better:_____

Describe the pain. (i.e sharp, dull,stabbing,achy,throbbing_____

Are you receiving any other type of medical treatment? _____ Please explain: _____

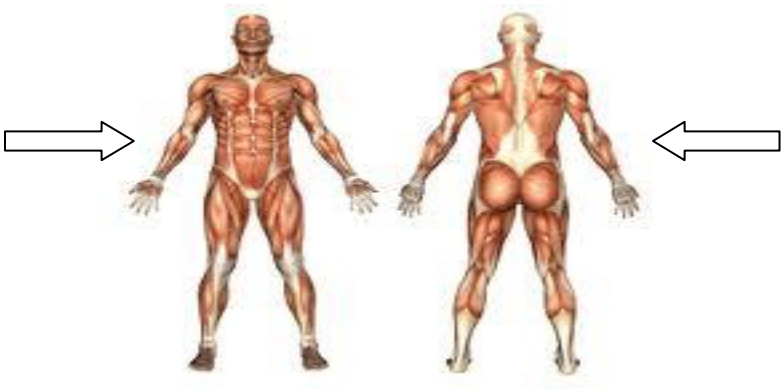
Please list any medication (vitamins, herbs or pharmaceutical) taken now or at regular intervals (include explanation of what medication is used to treat): _____

Are you currently under the care of a physician? [ ] Yes [ ] No Whom?_____Phone:_____

Please list reason(s): _____

Are there any other health concerns you wish to discuss today? _____ If yes, please describe: _____

Please indicate where you experience pain on the drawing below



Are you currently experiencing any of the following conditions?

_____ Flu or Cold _____ Inflammation _____ Fever _____ Infection _____ Contagious Disease

Please check any of the following conditions below that currently affect you or that you have experienced in the last 5 years.

MUSCULOSKELETAL
___ Fibromyalgia
___ Spasms/Cramps
___ Sprains/Strains
___ Osteoporosis
___ Postural Deviations
___ Gout
___ Osteoarthritis/Rheumatoid Arthritis
___ TMJ
___ Cysts
___ Bursitis
___ Plantar Fascitis
___ Tendonitis
___ Torticollis
___ Whiplash Syndrome
___ Carpal Tunnel Syndrome
___ Sciatica
___ Thoracic Outlet Syndrome
___ Headache
___ Leg Pain
___ Arm Pain/Shoulder Pain
___ Low Back Pain
___ Mid Back Pain
___ Hip Pain
___ Other _____

RESPIRATORY
___ Pneumonia
___ Sinusitis
___ Asthma
___ Trouble Breathing
___ Dizziness
___ Other_____

CIRCULATORY
___ Anemia
___ Hemophilia
___ Hypertension
___ Low Blood Pressure
___ Raynaud's Disease
___ Varicose Veins
___ Heart Condition
___ Blood Clots/Phlebitis
___ Diabetes
___ Other _____

DIGESTIVE
___ Ulcers
___ Irritable Bowel Syndrome
___ Colitis
___ Gallstones
___ Hepatitis
___ Crohn's Disease
___ Diarrhea
___ Gas/Bloating
___ Indigestion
___ Other _____

SKIN
___ Fungal Infections
___ Acne
___ Impetigo
___ Dermatitis/Eczema
___ Psoriasis
___ Open Wound or Sore
___ Rashes
___ Warts/Moles
___ Athletes Foot
___ Other _____

NERVOUS SYSTEM
___ ALS
___ Multiple Sclerosis
___ Parkinson's Disease
___ Bell's Palsy
___ Neuritis
___ Spinal Cord Injury
___ Stroke
___ Trigeminal Neuralgia
___ Seizure Disorders
___ Numbness/Tingling/Twitching
___ Other _____

OTHER
___ Insomnia
___ Anxiety/Panic Attacks
___ PMS
___ Grief Process
___ Cancer
___ Substance Abuse
___ Pregnancy
___ Chronic Fatigue
___ HIV/AIDS
___ Lupus
___ Kidney Disease
___ Bladder Infection
___ Postoperative Situation
___ Edema
___ Other _____

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) may be charged in full for the price of the missed session.

Signature:_____ Date:_____

Massage Therapy Informed Consent

I_____ , (client) understand that massage therapy provided by, ***Somatic Massage Therapy, P.C.*** *is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Any other intended purposes for massage therapy are specified below:*

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information. If I experience any pain or discomfort during the session, I immediately communicate that to the therapist so the treatment can be adjusted.

You may contact us for appointment reminders, schedule changes, Massage promotions or other needs by the following methods (fill in **only** *those methods by which you desire to be contacted):*

Home Telephone: _____ Work Telephone: _____
Cell Phone: _____ e-mail: _____
Home Address:_____Apt#_____
_____ _____
City _____ City_____
State/Province _____Postal code: _____ _____

Marketing: *Occasionally we send out Specials, Promotions and Discounts. If you do* ***NOT*** *wish to receive these, please check here: [ ]*