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 Fasciitis
___ 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
___ 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 _______________

Massage Therapy Customer Informed Consent

I, the undersigned patient, understands, acknowledges and agrees that:

(i) I am aware the facilities and services offered by Somatic Massage Therapy, P.C. involves risk.

(ii) I have provided all relevant information regarding my current health status.

(iii) I am seeking the Spa/Medical Massage services at my own free will; and

(iv) I assume all risk associated therewith. On behalf of myself and my heirs I hereby release and discharge Somatic Massage Therapy, P.C. (the "Owner") and all of their affiliates, employees, contractors, directors, officers, agents, landlords, representatives, successors and assigns of the owner from any and all claims or causes of actions arising out of or relating to spa services. Including but not limited to, those resulting from bodily injury, theft, loss of, or damage to property of mine unless due to the gross negligence of willful misconduct of Somatic Massage Therapy, P.C., It's owner or employees/contractors.

I, (*please initial*) ______ further, fully understand, acknowledge and agree all spa services, are provided exclusive as a convenience to me by Somatic Massage Therapy, P.C. and I accept the service(s) at my own risk and expense without liability or responsibility to the Spa or its affiliates.

Name (*print*): __________________________ Signature: __________________________ Date: ______________