

Carolyn O'Brien,
L.M.P.

Therapeutic Massage Personal Health Information

Date _____

First Name M.I. Last Name

Phone (day) Phone (evenings)

Address

City/State/Zip

Occupation

Date of Birth

Treatment Information -----

❖ Reason for visit: _____

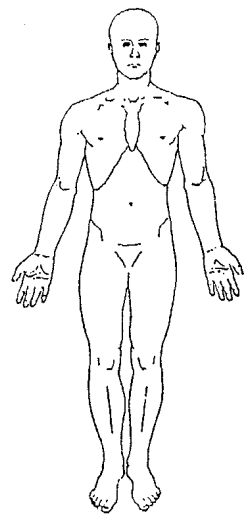
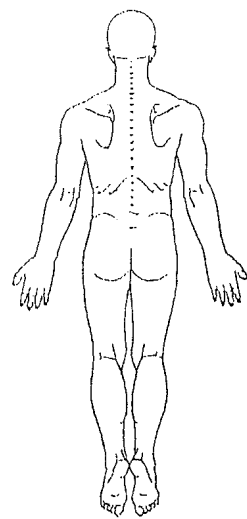
Is discomfort: () recent () chronic

❖ Have you ever received a professional therapeutic massage?
() no () yes, frequency? _____

❖ What results do you want from this massage?
() pain relief () relaxation () increased mobility

Please circle areas of discomfort _____

❖ What daily or repetitive activities aggravate this discomfort:
() computer () driving () lifting () reaching
() standing () other _____



Medical History -----

❖ Are you currently seeing a Medical practitioner? () no () yes, please explain

❖ Are you taking any medications? () no () yes, please list below

❖ Have you recently been: () ill () injured Please explain time & treatment below:

❖ Do you have a long-term: () illness () injury Please explain time & treatment below:

❖ Please list any surgeries:

Please mark only the items that apply to you:

- Allergies to natural:
() fragrances () oils () liniments
- Anxiety_____
- Breathing difficulty_____
- Blood Pressure: () high () low
- Cancer: What type?_____
- Cardiac disease: () chest pains
() pacemaker () by-pass surgery
- Circulatory problems:
() easy bruising () thrombophlebitis
() varicose veins () Raynaud's disease
- Contact Lenses (May be removed during treatment.)
- Communicable disease: () flu () cold
() hepatitis () HIV/AIDS () other_____
- Chronic Fatigue_____
- Diabetes:
() insulin injections () areas of numbness
() other concerns_____
- Digestive problems _____
- Female related: () PMS () Menstrual cramps
() Pregnant () Perimenopause () Menopause
- Fibromyalgia_____
- Lupus_____
- Lymphedema_____

Musculo-Skeletal

- Arthritis: What type & where?_____
- Bone or Joint disease_____
- Broken bones: Where?_____
- Bursitis_____
- Headaches: () migraine () tension
() head injuries_____
- Jaw pain/TMJ_____
- Low Back, Hip, Leg pain_____
- Neck, Shoulder, Arm pain_____
- Osteoporosis _____
- Sprains/Strains_____
- Spasms/Cramps_____
- Tendonitis_____
- Nerve problems: Discomfort to:
() heat () cold () pressure
- Radiating pain:
() down arms () down legs () other_____
- Sciatic nerve pain_____
- Seizures_____
- Sinus problems_____
- Skin problems: () athlete's foot () eczema
() open cuts, sores () rash () toe fungus

Diseases, conditions, injuries not mentioned here? _____

Questions? _____

Other: _____

It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my massage therapist any time I feel that my well-being is being compromised.

I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the massage therapist of any changes in my health status.

Signature_____ Date_____