

MASSAGE THERAPY CONFIDENTIAL SHEET

Welcome. We want to make your appointment as pleasant and comfortable as possible.
If at any time you have questions regarding your therapy session, please let us know.

Date: _____

Name: (Last) _____ (First) _____ (MI) _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Employer: _____ Occupation: _____

Marital Status: M W D S Left Handed Right Handed

Who referred you to our office, or how did you hear about us? _____

Have you ever received massage therapy? Yes No

Type of Massage Experienced: Swedish Deep Tissue Other When was your last massage? _____

Research is showing that many of our health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Childhood/Youth Years:	Yes	No	Explanation
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any falls from over 3 feet (i.e. crib, bed, trees)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you play sports?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you take/use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Was there any prolonged use of medicine's (i.e. antibiotics, inhaler)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you involved in any car accidents?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you suffer any form of abuse?	<input type="checkbox"/>	<input type="checkbox"/>	_____
By what method were you born? <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Vacuum			

Adulthood (18 to present):

Do/did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you play sports?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are you currently taking any prescription medications? Yes No

Please list (name, purpose & dosage):

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pin & needles in legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Upset stomach |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fever | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Problems Urinating | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Skin Sensitivities |

1) If you are experiencing a symptom, is it... (check more than one if necessary to describe your problem)

- Sharp Dull Burning Numbness & Tingling Pressure Comes & Goes Travels Constant

2) Where is the symptom? _____

3) When did the symptom first start? _____

4) Since the symptom started, it is...

- About the same Getting Better Getting Worse

5) What makes it worse: _____

6) Yes, it interferes with: Work Sleep Walking
 Sitting Hobbies Leisure

7) Does this cause you to be: Irritable Moody Worried

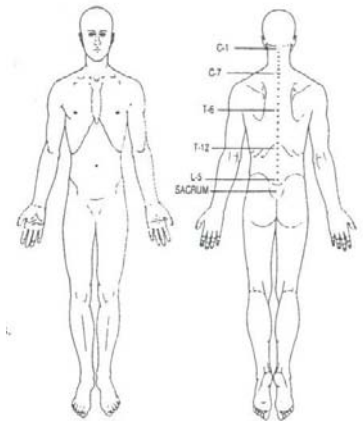
8) Is your Condition: Job Related Auto Accident Home Injury

9) Other Doctors seen for this problem and when (please list):

- Chiropractor _____ Medical Doctor _____ Other _____

10) Past Surgeries / Operations:

PLEASE INDICATE WITH AN (X), THE AREAS YOU ARE FEELING DISCOMFORT



Have you been examined for nervous system interference? Yes No Unsure

Have you ever had full spine x-rays? Yes No Unsure

Do you have scoliosis or degenerative discs? Yes No Unsure

Do you have any of the following **today**:

- Sunburn Inflammation Open cuts/bruises Irritated skin rash
 Headache Cold/flu Severe pain Poison ivy/oak

Do you have any allergies/sensitivities to any creams, oils, fragrances, etc.? Yes No Unaware

FEMALE ONLY: Is there any chance that you may be pregnant? Yes No

What are your Goals / Expectations for this therapy session?

By signing below, I understand and agree that this massage is not a replacement for medical care and that no diagnosis will be made. I also understand that I am responsible for paying for any services rendered.

Signature

Date