Personal Data and Health Screen

Name _____ Date of initial visit _____

Address _____

City _____ State _____ Zip code _____

Email _____

Referred by _____

Phone (day) _____ (eve) _____

Date of Birth _____

Occupation(s) _____

Interest(s) _____

What is your previous experience with professional massage/other bodywork? _____

What is your goal/concern for today's session? _____

Is there any area where you would like extra time spent, or any area where you seem to hold a lot of tension? _____ Any area you'd like skipped? _____

How were you referred? Friend (Name)_____ Ad_____Pathways Magazine_____
Yelp _____Doctor (Name) _____ Others_____

Lifestyle: Nutrition _____

Exercise _____

Tobacco _____Alcohol _____Drugs (non-med.) _____

Posture assumed most of day_____

Sleep_____Bowels_____Caffeine_____

Recreation_____

Do you wear contacts ( ), dentures ( ), hearing aid ( )

Are there specific aspects of your life that are particularly stressful (job, posture, habits, diet, family, etc.)? Explain.

Medical History: (give dates)

_____ Hypertension
_____ Heart disease
_____ Arteriosclerosis
_____ Varicose veins
_____ Phlebitis
_____Fluid retention
_____ Epilepsy
_____ Headaches
_____ Cancer/malignancy
_____ Diabetes
_____ Fractures

_____ PMS/painful menstruation
_____ Easy bruising
_____ Skin rash
_____ Abscess or open sore
_____ Skin sensitivity
_____ Allergies
_____ Herpes I or II
_____ HIV positive
_____ Other infectious diseases
_____ Mental illness

_____ Osteoporosis
_____ Osteoarthritis
_____ Rheumatoid arthritis
_____ Fibrositis
_____ Fibromyalgia
_____ Chronic Fatigue Syndrome
_____ Herniated disc
_____ Inner ear problem
_____ Pregnancy/Now
_____ Intrauterine Device

_____ Are you taking any medications? If so, what and what for?

_____

Medical History: *(Continued)*

_____ Surgery/fractures (explain) (dates):

_____ Implants of any kind:

_____ Prior injuries (explain) (dates):

_____ Musculoskeletal pain/stiffness (such as low back, neck, shoulder, etc. (explain) (dates):

_____ Any other physical or health difficulties?

_____ Any difficulty lying on your back, front, or turning?

To better develop a massage/bodywork session that meets your individual needs, it will be helpful to know if you have:

_____ Any counseling history:

_____ Any history of abuse (recent or past verbal, physical, sexual, or emotional):

_____ Any recent lifestyle/emotional challenge or loss:

_____ Are you under the care of a physician or other medical practitioner now? ( ) A counselor?

For what conditions?

_____ Do we have your permission to contact your physician should the need arise?

Name of physician_____Phone_____

This information will be treated confidentially. In order to maximize the effectiveness and safety of massage sessions together, please give your feedback during and at the end of the sessions. This will help in tailoring the massage session to serve in the best possible way.

* *

I have read the above information and discussed it with my practitioner. I understand that this work does not constitute medical treatment. It is a form of health and wellness maintenance utilizing the forms of traditional Swedish massage. I take responsibility for alerting my practitioner to any physical conditions that would affect this work.

Signature _____Date _____