

PATIENT INFORMATION

NAME _____ PHONE (_____) BIRTHDATE _____

ADDRESS/ CITY/ STATE/ ZIP _____

AGE _____ Male Female OCCUPATION _____ WORK PHONE (_____)

E-MAIL ADDRESS _____

EMERGENCY CONTACT _____ PHONE (_____)

PHYSICIAN _____ How did you hear about us? _____

CURRENT HEALTH: General and Medication Information

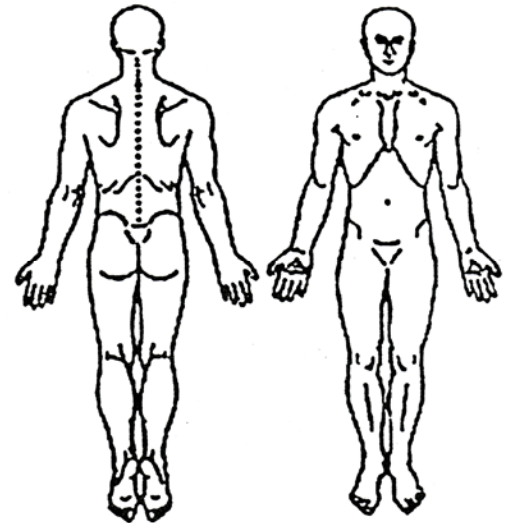
Are you basically in good health? Yes No Has there been a change in your health in the past year? Yes No
If YES, please explain _____

Have you ever received massage therapy or any form of bodywork before? Yes No
What is your primary concern or goal for today's session? _____

Please take a moment to carefully read the following questions and answer as indicated. If you have a specific medical condition or specific symptom, massage/bodywork may be contraindicated. A referral from your primary care provider may be necessary before service can be provided.

If you answer "YES" to any of these questions, please explain on the reverse side of this form.

- Yes No Do you have any allergies/sensitivities?
- Yes No Do you wear contact lenses?
- Yes No Do you suffer from arthritis or joint swelling?
- Yes No Do you have osteoporosis?
- Yes No Do you have diabetes?
- Yes No Do you have epilepsy or seizures?
- Yes No Do you have any cardiac or circulatory problems including any heart conditions or blood clots?
- Yes No Do you have difficulty breathing, or have asthma?
- Yes No Do you have cancer or any tumors/cysts?
- Yes No Are you pregnant or nursing?
- Yes No Do you have any infectious or contagious diseases?
- Yes No Have you had any broken bones in the past 2 years?
- Yes No Have you been in an accident or suffered from any injuries in the past 2 years?
- Yes No Do you suffer from claustrophobia?
- Yes No Is there any other medical condition I should know about?



MARK ON FIGURES THE AREAS OF:

- PAIN & TENDERNESS =O
- NUMBNESS OR TINGLING =Z
- SCARS, BRUISES, OPEN WOUNDS =H
- SWELLING OR STIFFNESS =X

Please list all medication (including non-prescriptions) you currently take:

CONSENT FOR CARE: It is my choice to receive massage therapy with Christine Graham - Massagebee Sports and Wellness Therapy. I am aware of the benefits and risks of massage and give consent for massage. I understand there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, or other qualified medical specialist for any ailment that I am aware of. I understand the massage/bodywork practitioners are not qualified to perform chiropractic adjustments, diagnose, prescribe, or treat any physical and mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability of the practitioner's part should I fail to do so.

CLIENT SIGNATURE _____ DATE _____