Solitude Massage

Name: First _____ Middle _____ Last _____

Address _____ City, Zip _____

Phone: Daytime _____ Home _____ Cell _____

Email _____ Referred By _____

Birth Date _____ Marital Status: ❑ Married ❑ Single ❑ Divorced

Occupation _____ Employer _____

Insurance? ❑ No ❑ Yes Insurance Name _____

Policy Number _____

Emergency Contact: Name _____ Phone _____

Physician: Name _____ Phone _____

Massage Information

First professional massage? ❑ Yes ❑ No; How frequently do you have massages? _____

Medical Information

Do you wear contact lenses? ❑ Yes ❑ No Are you allergic to peanuts? ❑ Yes ❑ No

List accidents/injuries, hospitalizations, and surgeries; when they occurred and treatment received.

Any lingering effects from the above or do you feel you have recovered?

Chronic, ongoing pain? ❑ No ❑ Yes, please describe and list any care or treatment you receive

Do activities affect the pain? ❑ No ❑ Yes, please describe

Are you currently being treated medically or taking prescribed drugs? ❑ No ❑ Yes, please describe

Please list all over the counter medications, supplements, and/or herbs taken and why

_____

_____

_____

History (helps determine treatment options)

Musculosketal
- ❑ Osteoporosis
- ❑ Arthritis
- ❑ Hypothyroidism
- ❑ Fibromyalgia
- ❑ Chronic Fatigue
- ❑ Gout in _____
- ❑ Bursitis
- ❑ Plantar Fascitis
- ❑ Cysts/Lipomas
- ❑ TMJ
- ❑ Chronic Headaches
- ❑ Tendonitis
- ❑ Whiplash
- ❑ Strains/Sprains
- ❑ Chronic pain in:
  - ❑ Neck
  - ❑ Low-back
  - ❑ Mid-back
  - ❑ Upper-back
  - ❑ Hip
  - ❑ Arm
  - ❑ Leg
  - ❑ Shoulder
  - ❑ Wrist/Hand
- ❑ On computer more than 2 hrs/day. Nbr of hrs: _____

Respiratory
- ❑ Pneumonia
- ❑ Asthma
- ❑ Breathing Problems
- ❑ Sinusitis
- ❑ Other: _____ _____

Digestive
- ❑ Ulcers
- ❑ Colitis
- ❑ IBS
- ❑ Crone's Disease
- ❑ Gluten Intolerance
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gallstones
- ❑ Gas/Bloating
- ❑ Chronic Indigestion

Circulatory
- ❑ Heart Problems _____ _____
- ❑ Stroke
- ❑ Palpitations
- ❑ Mitral valve prolapse
- ❑ Anemia
- ❑ Hemophilia
- ❑ Hypertension
- ❑ Low Blood Pressure
- ❑ Peripheral Artery Disease
- ❑ Raynaud's Disease
- ❑ Varicose veins
- ❑ Blood clots/Phlebitis

Skin
- ❑ Fungal infections
- ❑ Athlete's Foot
- ❑ Impetigo
- ❑ Eczema/Dermatitis
- ❑ Psoriasis
- ❑ Easily irritated skin
- ❑ Other: _____

Nervous System
- ❑ Dizziness
- ❑ ALS
- ❑ Multiple Sclerosis
- ❑ Parkinson's Disease
- ❑ Bell's Palsy
- ❑ Neuritis
- ❑ Spinal cord injury
- ❑ Trigeminal Neuralgia
- ❑ Seizures/Epilepsy

Other
- ❑ Diabetes
- ❑ Pregnancy
- ❑ Cancer
- ❑ Kidney disease
- ❑ Hepatitis
- ❑ HIV/AIDS
- ❑ Lupus
- ❑ Postoperative: _____
- ❑ Cystitis
- ❑ High stress
- ❑ Grieving
- ❑ Anxiety/Panic Attacks
- ❑ Bipolar syndrome
- ❑ PMS/Menopause difficulties
- ❑ Poor sleep/Insomnia
- ❑ Allergies affecting:
  - ❑ Facial skin
  - ❑ Body skin
  - ❑ Nose/Sinuses
  - ❑ Eyes
  - ❑ Stomach/Gut
- ❑ Orthopedic pins or plates
- ❑ Other: _____

Exercise

Time/day-week: _____ Activities: _____

_____

The above information is accurate. I understand that Massage Therapists do not diagnose or prescribe drugs and that they are not a substitute for medical care. I agree to alert my practitioner of any physical or emotional changes as they occur. I also understand that a missed appointment might incur charges that I must pay.

Signature _____ Date _____