Awakening Touch MASSAGE

Medical massage

Name	Date
Address	
City	State Zip
E-Mail	Date of Birth
Cell Phone	Home Phone
Occupation	Referred by
Emergency contact	Phone number

Have you previously experienced medical massage therapy? YES NO If so, date:

Are you currently under a physician's care for any conditions? YES NO

If yes, please describe _____

_____

Primary reason for today's visit? _____

_____

Areas of complaint, pain, tension? _____

_____

Medical massage

Please list current medications and the conditions they are treating.

How would you describe your activity level? (i.e. exercise, sports, etc.)

Please list any major accidents or surgeries (including dates).

Please present any internal pins, artificial joints, or special equipment.

Have you ever received any other treatments? (Chiropractic, Naturopathic, Acupuncturist, etc.)

Do you have any difficulty laying on your back or front, or turning over?

Are you comfortable with your therapist asking personal questions as they pertain to your session?

Are there specific aspects of your life that are particularly stressful? (i.e job, home life, body concern, etc.)

Medical massage

Head/Neck

- ☐ Headache/migraines
- ☐ Ringing in ears
- ☐ Vision problems
- ☐ Vertigo/dizziness
- ☐ Hearing loss
- ☐ Vision loss

Respiratory

- ☐ Asthma
- ☐ Chronic cough
- ☐ Frequent colds
- ☐ Shortness of breath
- ☐ Sinusitis

Nervous System

- ☐ Sensory loss/change
- ☐ Sciatica
- ☐ Seizures
- ☐ Numbness/tingling
- ☐ Epilepsy

Musculoskeletal System

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Bursitis
- ☐ Tendonitis
- ☐ Jaw pain (TMJ)

Cardiovascular

- ☐ High/low blood pressure
- ☐ Heart attack
- ☐ Heart disease
- ☐ Varicose veins
- ☐ Chronic congestive heart failure
- ☐ Stroke
- ☐ Poor circulation
- ☐ Pace maker

Skin and Infections

- ☐ Hepatitis
- ☐ Herpes
- ☐ Lyme disease
- ☐ HIV/AIDS
- ☐ Infectious skin conditions

Other Conditions

- ☐ Cancer _____
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Diabetes I or II
- ☐ Digestive conditions
- ☐ Chronic fatigue syndrome
- ☐ Anxiety
- ☐ Other conditions

Medical massage

I understand the bodywork I receive is provided for the purpose of relaxation, relief of muscular tension, general health and well-being improvements. I am aware of the benefits and the risks of massage and give my consent for treatment massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or a series of appointments. If I experience any pain or discomfort during or after the session or further sessions, I will immediately inform the practitioner so that the pressure and or the position may be adjusted to my level of comfort. I acknowledge that bodywork is not a substitution for medical care, medical examination or diagnosis. I have stated all my medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

I have completed the above information accurately and have read, understood, and take responsibility for the above statements.

Signature _____ Date _____

Cancellation Policy

A 24-hour advance notice is required when canceling any appointments, except in case of illness or emergency. Cancellations without 24-hours notice will result in full payment charges.

I have read and understand this cancellation policy.

Signature _____ Date _____