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Massage Therapy New Patient Form

Name: ____ DOB: _____________________Age: _______
Sex: ☐ Male ☐ Female Height: ______________________ Weight: ________________________________
Home Address: ____
Street *City* *State* *Zip*
Phone Number: ________________________________ Work Number: _______________________________
Family Physician: _________________________________ Date of Last Exam: _________________________
Occupation: _________________________________ Employer: ____________________________________
Medication Presently Taking: ____
Major Operations: ____
Do you experience shortness of breath? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No If Yes, how much per day? ______________ Cigarettes/Pipe/Cigar/Other

Have you had, or do you have any of the following problems? Check any that are applicable to you:

☐ Cysts, tumors, cancer	☐ Cold hands/feet	☐ Ulcers
☐ Tuberculosis	☐ Bruise easily	☐ Anemia
☐ Low Blood Pressure	☐ Constipation	☐ Strokes
☐ High Blood Pressure	☐ Water retention	☐ Diarrhea
☐ Heart Problems	☐ High fever	☐ Diabetes
☐ Kidney Problems	☐ Back Problems	☐ Indigestion
☐ Bladder Problems	☐ Allergies	

Indicate problem areas:

Head and Neck	**Digestive**	**Skin**
☐ Frequent Headaches	☐ Bloated Stomach	☐ Bruises easily
☐ Neck pain/tightness	☐ Constipation	☐ Open cuts/sores
☐ Neck lumps or swelling	☐ Loose Bowels	☐ Hypersensitivity
Musculoskeletal		**Cardiovascular**
☐ Aching Muscles	☐ Painful Feet	☐ High Blood Pressure
☐ Aching Joints	☐ Carpal Tunnel Syndrome	☐ Low Blood Pressure
☐ Lower back pain	☐ Tennis Elbow	☐ Swollen feet

☐ Shoulder pains		☐ Leg Cramps
Neurological	**Eyes**	**Respiratory**
☐ Difficulty relaxing	☐ Wear Glasses	☐ Breathing Difficulty
☐ Difficulty sleeping	☐ Wear Contacts	

What do you hope to accomplish from your massage treatments?
____
____

Indicate diagnosed Illness with a (D) if not currently being treated or a (T) if currently being treated:

__ Arthritis/Rheumatism	__ Ulcers	__ CVN stroke
__ Disease of bones/joints	__ Kidney/Bladder ailment	__ Tuberculosis
__ Neuritis/Neuralgia	__ Colitis/Bowel disorder	__ Hypertension
__ Sciatica	__ Epilepsy	__ HIV +
__ Broken bones(s) Where?	__ Sprain/dislocation Where?	__ AIDS
__ Heart Disease Type?	__ Cancer/tumors Where?	__ Other

AIDS clients, please note specific diagnosis and medications that can affect method of therapy:
____
____

For Women Only: ☐ Pregnant ☐ Lump/Pain in Breast(s) ☐ Cramps
Date of Last Period: ___________________________________

Client Agreement

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation, stress reduction, relief of muscular tension, or therapeutic applications.

If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

I further understand that massage/bodywork should not be considered as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of.

Because massage/bodywork is contraindicated (should not be done) 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 in the practitioner's part should I forget to do so.

It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of session, and I will be liable for payment for the "full" scheduled appointment.

Client Signature: ____ Date: ____________________________

Practitioner: ____ Date: ____________________________