

Physical Edge Orthopedic Massage and Pain Management

Health History & Consent for Massage

Name: _____ Today's Date: _____ Date of Birth: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: Home: _____ Cell/Work: _____ E-mail: _____
 Occupation: _____ Referred By: _____ Have you had therapeutic massage before? Y N
 What type of massage have you had? Swedish ___ Deep Tissue ___ Relaxation ___ Other _____
 What are your goals / expectations for this session? _____
 Health Insurance Carrier: _____ If Preferred Care, your session may be covered at a co-pay rate.
 Emergency Contact: _____ Phone Number: _____

Are you currently being treated by a health care practitioner? Y N
 If so, for what purpose? _____ Are you pregnant or attempting to be? _____
 List previous surgeries and dates: _____

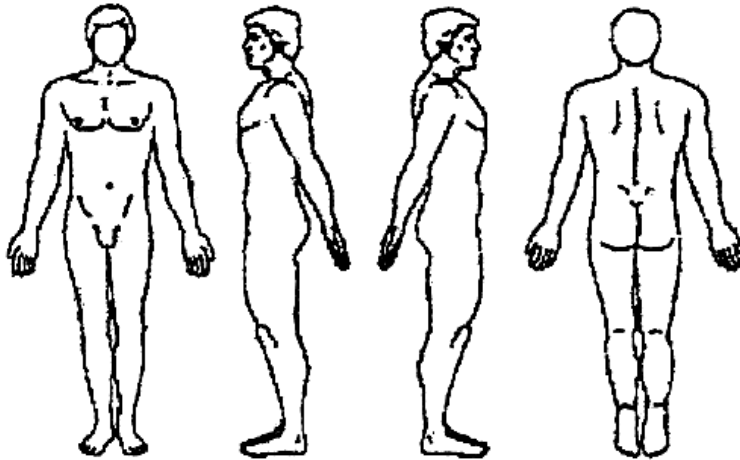
Please **X** conditions you are experiencing and **circle** conditions that you have experienced in the past.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Allergies skin/food | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Nerve damage | <input type="checkbox"/> Skin disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Swollen joints |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Infectious conditions | <input type="checkbox"/> Pins & needles | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Kidney condition | <input type="checkbox"/> Ruptured/bulging disc | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Liver condition | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Scoliosis | _____ |

List current medications including supplements, prescription drugs, over the counter & herbs: _____

What activities do you perform most often? Sitting _____ Standing _____ Lifting _____ Bending _____
 List any repetitive movements and the general frequency with which you perform them: _____

Please indicate areas of discomfort on the figures below:



Please read the following and sign below:

I understand that the above information is strictly confidential and is used to help the Massage Therapist determine any indications or contraindications for massage. I understand that the unclothed body will be properly draped at all times to ensure warmth, security, and as a mark of massage professionalism. I agree to provide accurate health information and notice of any health changes prior to receiving massage today and in the future. I will immediately inform the therapist of any unusual sensations or discomfort so that the application of massage can be adjusted to my comfort level. I understand that massage is not sexually oriented in any way and that any illicit or suggestive remarks or behavior on my part will result in termination of the session. I understand that by signing this form, I give my consent to receive the treatment in this and all future sessions and agree that my presence at subsequent sessions shall be construed to be validation of this written consent. I have read this form and freely give my permission to receive massage.

Signature: _____ Date: _____