

Please check all current , previous conditions and explain. Thank you

Current = C Past= P

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**General**

Headaches \_\_\_\_\_  
Pain \_\_\_\_\_  
Sleep Disturbances \_\_\_\_\_  
Fatigue \_\_\_\_\_  
Infectious \_\_\_\_\_  
Fever \_\_\_\_\_  
Sinus \_\_\_\_\_  
Other \_\_\_\_\_

**Skin Conditions**

Rashes \_\_\_\_\_  
Athlete's Foot, Warts \_\_\_\_\_  
Other \_\_\_\_\_

**Allergies**

Scents, Oils, Lotions \_\_\_\_\_  
Detergents \_\_\_\_\_  
Other \_\_\_\_\_

**Muscles, Bones and Joints**

Rheumatoid Arthritis \_\_\_\_\_  
Osteoarthritis \_\_\_\_\_  
Osteoporosis \_\_\_\_\_  
Scoliosis \_\_\_\_\_  
Broken Bones \_\_\_\_\_  
Spinal Problems \_\_\_\_\_  
Disk Problems \_\_\_\_\_  
Lupus \_\_\_\_\_  
TMJD, Jaw Pain \_\_\_\_\_  
Spasms, Cramps \_\_\_\_\_  
Sprains, Strains \_\_\_\_\_  
Tendonitis, Bursitis \_\_\_\_\_  
Stiff or painful Joints \_\_\_\_\_  
Weak or sore muscles \_\_\_\_\_  
Neck, Shoulder, Arm Pain \_\_\_\_\_  
Low back, Hip or leg pain \_\_\_\_\_  
Other \_\_\_\_\_

**Nervous System**

Head Injuries \_\_\_\_\_  
Concussions \_\_\_\_\_  
Dizziness, Ringing in the ears \_\_\_\_\_  
Loss of Memory, confusion \_\_\_\_\_  
Numbness, Tingling \_\_\_\_\_  
Sciatica, Shooting pain \_\_\_\_\_  
Chronic Pain \_\_\_\_\_  
Depression \_\_\_\_\_  
Stroke \_\_\_\_\_  
Other \_\_\_\_\_

**Respiratory, Cardiovascular**

Heart Disease \_\_\_\_\_  
Blood Clots \_\_\_\_\_  
Stroke \_\_\_\_\_  
Lymphadema \_\_\_\_\_  
High blood Pressure \_\_\_\_\_  
Low blood pressure \_\_\_\_\_  
Irregular Heart Beat \_\_\_\_\_  
Poor Circulation \_\_\_\_\_  
Swollen Ankles \_\_\_\_\_  
Varicose Veins \_\_\_\_\_  
Chest Pain, Shortness of Breath \_\_\_\_\_

Asthma \_\_\_\_\_

**Digestive/ Elimination System**

Bowel Dysfunction \_\_\_\_\_  
Gas, Bloating, \_\_\_\_\_  
Bladder/kidney dysfunction \_\_\_\_\_  
Abdominal Pain \_\_\_\_\_  
Other \_\_\_\_\_

**Endocrine System**

Thyroid Dysfunction \_\_\_\_\_  
Diabetes \_\_\_\_\_

**Reproductive System**

Pregnancy \_\_\_\_\_  
Painful, Emotional Menses \_\_\_\_\_  
Fibrocystic Cysts \_\_\_\_\_

**Cancer/Tumors**

Benign \_\_\_\_\_ Malignant \_\_\_\_\_  
Year of Diagnosis if Malignant \_\_\_\_\_  
Location \_\_\_\_\_  
Under current Treatment \_\_\_\_\_

**Habits**

Tobacco, alcohol, Drugs, Coffee or  
soda \_\_\_\_\_

**Any medical conditions not listed  
previously**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all conditions that are being monitored by a health care provider:

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List all medications you took today, including Pain relievers both RX and OTC as well as herbal med

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List all other medications taken in the last 3 months:

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Are you or have you been recently ill with a cold, flu or other infectious condition?

Yes \_\_\_\_\_ or No \_\_\_\_\_

If yes, massage may not be indicated, please discuss this with your therapist.

**Contract for Care**

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plans based on the information provided by my massage therapist and other members of my health care team, and my experience of those suggestions. I agree to participate in the self care program we select. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I expect my massage therapist to provide safe and effective treatment.

**Consent for Care**

It is my choice to receive manual therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name if signing for minor \_\_\_\_\_ Relationship \_\_\_\_\_