Mercy

Mercy Integrative Medicine
Massage Therapy Client Health Information Form

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-Mail Address _____ Occupation _____

Emergency Contact _____

Referred by _____

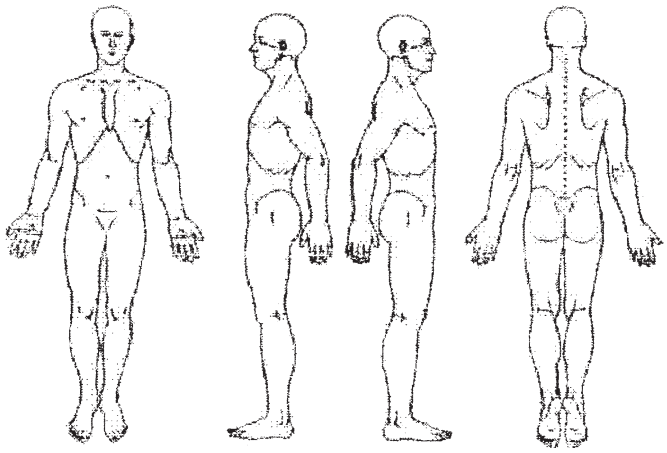
Do you prefer to be contacted at ___ Home ___ Work ___ Both

Have you ever received a professional massage? ___ Yes ___ No

What is the main reason why you want to receive a massage? _____

On the diagrams below, mark the area(s) of your body where you experience pain, tension, numbness, tingling, spasms, cramps and/or where you have scars.

XXX	Pain
/////	Tension
***	Spasms/Cramps
~~	Scars
----	Numbness



Please rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____

Below, mark the areas of your body that you would like the *therapist to concentrate on:*

___ Neck ___ Low back ___ Legs ___ Face ___ Chest ___ Arms

___ Buttocks ___ Upper back ___ Feet ___ Scalp ___ Abdomen ___ Hands

Below, please mark the areas of your body that you **DO NOT** want the therapist to massage:

___ Neck ___ Low back ___ Legs ___ Face ___ Chest ___ Arms

___ Buttocks ___ Upper back ___ Feet ___ Scalp ___ Abdomen ___ Hands

Are you currently under the care of a health care professional? ___ Yes ___ No

If yes, for what condition? _____

Please turn page over, complete and sign

List any surgeries you have had, including this year: _____

_____

List any accidents (including auto) and/or injuries and/or falls you have had: _____

_____

List medications (including over-the-counter) you are currently taking and why: _____

_____

Do you have skin sensitivities or skin allergies (to include latex)? ___ Yes ___ No If yes, explain _____

Other allergies? _____

Do you exercise or play sports on a regular basis? ___ Yes ___ No Comments: _____

Are you wearing contacts? ___ Yes ___ No Comments: _____

For women only: Are you pregnant or think you may be pregnant? ___ Yes ___ NoDue Date _____

Do you have any questions/concerns regarding your nutrition? ___ Yes ___ No If yes, please list _____

_____

Please check if you have had any of the following conditions:

___ AIDS	___ Constipation	___ Fractured bone(s)	___ Low blood pressure
___ Allergies	___ Contagious disease	___ Frequent colds	___ Musculoskeletal disease
___ Arthritis, (osteo)	___ Depression	___ Frequent headaches	___ PMS
___ Arthritis, (rheumatoid)	___ Diabetes	___ Heart condition	___ Sinus condition
___ Asthma	___ Dizziness	___ Hepatitis	___ Sleep disorder
___ Athletes foot	___ Eating disorder	___ Herpes/shingles	___ Sprain/strain
___ Broken bones	___ Epilepsy	___ High blood pressure	___ TMJ
___ Cancer	___ Fibromyalgia	___ HIV	___ Varicose veins

___ Other conditions _____

Please read the following and sign:

I understand that the massage I receive is provided for the basic purpose of relaxation, stress reduction, relief of muscular tension or for increasing circulation and energy flow. If I experience any pain or discomfort during this massage session, I will immediately inform the massage therapist.

I understand that the massage therapist does not diagnose diseases, illnesses or any other physical or mental disorder. Also, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulations.

I have disclosed all health information truthfully and in full.

Client Signature _____ Date _____