RN Wellness Massage

Name _____**E-mail**_____ **Date of Birth** _____

Address _____ **Home Phone** _____

City_____ **State**_____ **Zip**_____ **Cell Phone** _____

How did you hear about us? _____
Have you received a professional massage before today? _____
Primary reason for appointment today: _____

Are you currently taking any pain medication or physician prescribed medications? If yes, please list below:

Medication:	Prescribed for:

Have you had any **major surgeries or injuries** that your massage practitioner needs to be aware of? _____
If yes, please make note of it in the space provided:

Surgery	Date

Injury	Date

Do you have allergies to nuts, lotions, oils, creams, or scents? If yes, please describe _____

If you wear any of the following, **please check**: ☐ Contact lenses ☐ Dentures ☐ Hearing aids

If you have any of the following medical devices, **please check:** ☐ Insulin pump ☐ Pacemaker ☐ Bone pins ☐ Spinal rods

Below is a list of medical conditions. Keep in mind that some medical conditions may require you to have a physician's release form to receive massage. In some situations massage may not be advisable, but in most cases a session can be modified to suit your needs.

If you are currently dealing with any of the conditions listed below, place a check in the appropriate area.

Blood, Heart and Circulatory
Anemia ☐
Aneurysm ☐
Arteriosclerosis ☐
Bruise Easily ☐
Circulatory Disorder ☐
Congestive Heart Failure ☐
Clotting Disorder ☐
Edema ☐
Heart Attack ☐ Stents_____
High Blood Pressure ☐
Irregular Heart Palpatations ☐
Low Blood Pressure ☐
Lymphedema ☐
Stroke ☐ Mini ☐ Major ☐
Valve Disorder ☐
Varicose veins ☐

Cancer
Breast ☐ Date of last treatment _____
Colon ☐ Date of last treatment _____
Skin ☐ Date of last treatment _____
Other: _____

Auto Immune, Endocrine, and Nervous System
Diabetes ☐ Type I ☐ or Type II ☐
Fibromyalgia ☐
Lupus ☐
Multiple Sclerosis ☐
Neuropathy ☐
Parkinsons Disease ☐

Respiratory
Asthma ☐
Bronchitis ☐
Chronic Cough ☐
Emphysema ☐
Seasonal Allergies ☐
Shortness of Breath ☐
Pneumonia ☐

Viral
Herpes ☐ I ☐ II ☐
Hepatitis ☐
Shingles Outbreak ☐
Warts ☐ Location _____

Bone, Joint & Muscle
Bulging Disc/s ☐
Carpal Tunnel Syndrome ☐
Osteoarthritis ☐ Location: _____
Rheumatoid Arthritis ☐
Muscle cramps or spasms ☐

Chronic Pain
Back ☐
Hip/s ☐
Knees ☐
Neck ☐
Shoulder joints ☐

Do you suffer from:
Headaches ☐ Migraine ☐ Tension ☐

Women Only:
Are you pregnant ☐ Due Date: _____
Children and ages _____
Menopausal Symptoms ☐

Have you had cancer within the last five years? _____ Any metastasis? _____
Is there any condition not listed above that your massage practitioner needs to be aware of? If yes, please list: _____

_____

I understand that the massage therapy given here is for the purpose of stress reduction, relief from muscular tension, or for increasing circulation. I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder.

Client Signature: _____ **Date**_____