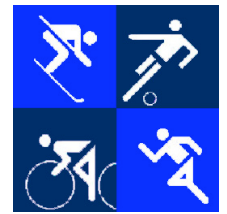


stressFX

Sports massage for the athlete in all of us.



Name _____ Date of Birth ____/____/____ Height _____ Weight _____

Address _____ City _____ State _____ Zip _____

Primary Phone (____) _____ (W H C) Secondary Phone (____) _____ (W H C)

E-mail _____ How did you hear about our office? _____

Emergency Contact _____ Phone (____) _____ Relationship _____

Occupation _____ Marital Status _____ Number of Children _____

Are you currently, or have you recently, been treated by a physician? If so, please explain. _____

List any prescriptions, over-the-counter medications, supplements, or herbs you are currently taking and why.

Please list anything to which you are allergic (nuts, oils, etc.). _____

Please list any recent and past surgeries, operations, broken bones, etc. _____

If you have you ever been involved in an auto accident, please note the date and briefly explain your injuries.

Major complaint / Reason for today's visit _____

Secondary complaint _____

For the protection of both you and the therapist, please check any of the following that apply to you.

Pain

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> face | <input type="checkbox"/> jaw | <input type="checkbox"/> neck | <input type="checkbox"/> chest |
| <input type="checkbox"/> upper back | <input type="checkbox"/> mid back | <input type="checkbox"/> lower back | <input type="checkbox"/> abdomen |
| <input type="checkbox"/> R L shoulder | <input type="checkbox"/> R L arm | <input type="checkbox"/> R L elbow | <input type="checkbox"/> R L hand |
| <input type="checkbox"/> R L hip | <input type="checkbox"/> R L leg | <input type="checkbox"/> R L knee | <input type="checkbox"/> R L foot |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> tendonitis | <input type="checkbox"/> bursitis | <input type="checkbox"/> numbness / tingling / spasms |
| <input type="checkbox"/> artificial joints | <input type="checkbox"/> degenerated discs | <input type="checkbox"/> internal pins/wires/screws | |

Health

- | | | |
|--|---|--|
| <input type="checkbox"/> contact lenses | <input type="checkbox"/> hearing aids | <input type="checkbox"/> orthotics |
| <input type="checkbox"/> vision impairment | <input type="checkbox"/> hearing impairment | <input type="checkbox"/> allergies / sinus infection |
| <input type="checkbox"/> headaches / migraines | <input type="checkbox"/> dizziness / vertigo | <input type="checkbox"/> eye strain |
| <input type="checkbox"/> heart disease/attack | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> low blood pressure |
| <input type="checkbox"/> pacemaker | <input type="checkbox"/> blood clots | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> stroke / CVA | <input type="checkbox"/> epilepsy | <input type="checkbox"/> depression / anxiety disorder |
| <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> chronic fatigue syndrome |
| <input type="checkbox"/> bruise easily | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> rash / eczema / psoriasis |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> IBS / diverticulitis | <input type="checkbox"/> asthma / emphysema / bronchitis |
| <input type="checkbox"/> hepatitis | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> cancer (type _____) |
| <input type="checkbox"/> severe cold / flu | <input type="checkbox"/> insomnia | <input type="checkbox"/> pregnancy (due date _____) |

Do you have any other *health* challenges? If so, please explain. _____

Is there any other information that the therapist should know? _____

This health survey is confidential, as is the treatment. The therapies offered are designed to compliment your current health practices. Information exchanged during treatment is educational in nature and is to be used at your discretion. Please understand that massage therapy is not a replacement for a medical diagnosis or treatment. If serious symptoms persist, you should contact your physician. This massage is for therapeutic purposes only. It is completely non-sexual. By signing below, you accept these terms and conditions.

Signature

Date

Your appointment time has been set aside especially for you. If you are unable to keep the appointment, please provide 24 hours notice so others who are waiting have the opportunity to reserve that time. If you fail to provide 24 hour notice you may be charged for services, except in cases of emergency. Your understanding and cooperation is greatly appreciated.