Massage Case History/Patient Information

Date:_____ Patient #_____ Doctor**: Debbie Moore, DC** Therapist**: Christopher Griffith**

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____ Cell or Alternate Phone:_____

Age:_____ Birth Date:_____ Marital Status: Married Single Widowed Divorced

Occupation:_____ Employer:_____

How were you referred to our office?_____

Family Medical Doctor:_____ Clinic Name: _____

May we have your permission to update your medical doctor regarding your care at this office? Yes No

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or a similar condition? No (describe) _____

Have you ever had a professional Massage? Yes No When was your last massage? _____

What do you hope to accomplish with today's Massage? _____

Do you suffer from Back Pain? Yes No Do you suffer from Neck Pain? Yes No Do you experience Headaches? Yes No

What Type of Pain? Sharp Dull Achy Spasms Pain with Movement Numbness Tingling Pain while sleeping

Do you have tension or soreness in a specific area? No (indicate) _____

What makes your pain or condition better? _____

What makes your pain or condition worse? _____

Are you sensitive to touch (ticklish or pain) or pressure in any areas? No (indicate) _____

Are you allergic or sensitive to any oils (Essential Oils, Nut Oils, Scents)? No (Indicate) _____

What is your posture during most of the day? Sitting Standing Stooping Bending Kneeling Lifting Driving Walking Running

Are You Pregnant? Yes No What type of exercise and how often ? _____

Please Mark any areas where you have discomfort or pain

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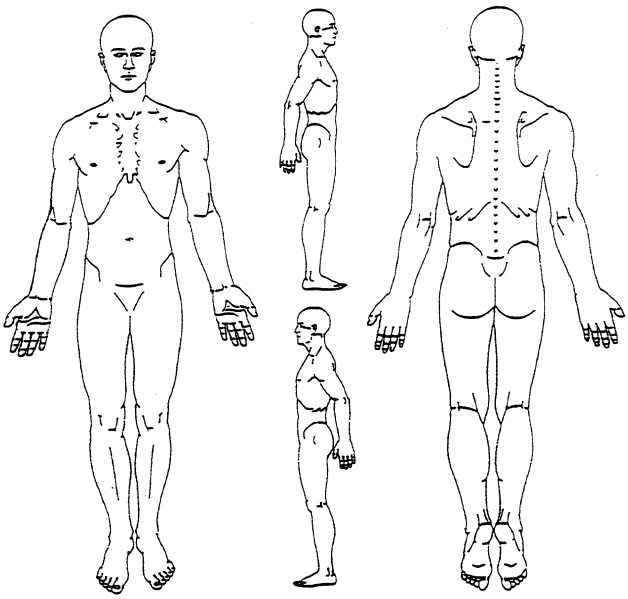

Please provide any additional Information about your health to assist your therapist in providing a beneficial and therapeutic massage (previous injuries, goals for massage, etc.)

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Massage Information and Informed Consent

Please read and Initial each item to indicate understanding and agreement.

_____ I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension and improvement of circulation and energy flow.

_____ If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsile for any pain or discomfort I experience during or after the session.

_____ I affirm that I have notified my therapist of all known medical conditions and injuries.

_____ I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part, if I should forget to do so.

_____ I understand that massage is entirely therapeutic and non-sexual in nature.

_____ I understand that the therapist may recommend a doctors visit before or after any treatment, if my symptoms require it, or if there is no improvement after a reasonable amount of time.

_____ I understand that I may use my insurance and that there *may* be additional paperwork or exams that need to be completed.

By signing this release, I hereby waive and release my therapist from any and all liability, past, present and future relating to massage therapy and body work.

Signed _____ Date _____

In Preparation for Your Massage

- Prior to your massage, please remove contact lenses and all jewelry. Pull long hair back with a clip or band.
- In general, massage is given while you are unclothed. However, you may choose to wear undergarments or a swimsuit. You will be covered with a top sheet throughout your session. This is your massage and you should be as comfortable as possible.
- Feel free to ask for less pressure or deeper pressure in certain areas, if needed.
- Feel free to ask your therapist any questions before, during or after the session. Your therapist is a highly trained professional and will be happy to make you feel informed and comfortable.