The Massage Pad

Name ______________________________ Date ____________________

Address ________________________City ______________ ZIP __________

Day Phone (   )_____________ Evening Phone (   )______________

Date of Birth _____________ E-mail ________________________________

Emergency Contact __________________ Phone (   ) _________________

Have you ever received a massage before? Yes No

Do you have any goals you are hoping to achieve through massage?
Check all that apply

___*Relief of muscle aches and pains*
___*Increase range of motion*
___*Eliminate headaches*
___*Gain better body awareness*
___*Relax...*
___*Other*____

My primary area of concern is:______________________________________

Diagnosis and/or treatment received?__________________________________

Are you currently seeing a Health Care Provider for this condition? Yes No

My secondary area of concern is: ____________________________________

Diagnosis and/ or treatment received?

Are you currently seeing a Health Care Provider for this condition? Yes No

Training for an event? If yes, please list______________________________
Are there any activities or sports you participate in that relate to your massage goals? If yes, please explain____

Communication can make all the difference in receiving a great treatment for you as an individual. Every person has a different idea of the perfect treatment. Is there anything that would make your treatments especially suited to you or not suited to you the I should be aware of?

____

On the backside please mark all that apply.

General

Current/Past

- ☐ ☐ Headaches
- ☐ ☐ Pain
- ☐ ☐ Sleep Difficulties
- ☐ ☐ Fatigue
- ☐ ☐ Infection
- ☐ ☐ Fever
- ☐ ☐ Sinus
- ☐ ☐ Thyroid Dysfunction
- ☐ ☐ Diabetes
- ☐ ☐ Tobacco
- ☐ ☐ Alcohol
- ☐ ☐ Drugs
- ☐ ☐ Caffeine
- ☐ ☐ Other

Skin Conditions

Current/ Past

- ☐ ☐ Rashes
- ☐ ☐ Athlete's Foot
- ☐ ☐ Warts
- ☐ ☐ Other

Allergies

Current/ Past

- ☐ ☐ Scents
- ☐ ☐ Oils/Lotions
- ☐ ☐ Detergents
- ☐ ☐ Other

Digestive/Elimination

Current/ Past

- ☐ ☐ Bowel Dysfunction
- ☐ ☐ Gas/Bloating
- ☐ ☐ Bladder Dysfunction
- ☐ ☐ Abdominal Pain
- ☐ ☐ Ulcers
- ☐ ☐ Other

Reproductive System

Current/Past

- ☐ ☐ Pregnancy
- ☐ ☐ Painful Menses
- ☐ ☐ PMS
- ☐ ☐ Fibrotic cysts
- ☐ ☐ Endometriosis

Cancer

Current/ Past

- ☐ ☐ Benign
- ☐ ☐ Malignant

Respiratory/Cardio

Current/ Past

- ☐ ☐ Heart Disease
- ☐ ☐ Blood Clots
- ☐ ☐ Stroke
- ☐ ☐ Lymphedema
- ☐ ☐ High/Low BP
- ☐ ☐ Irregular HR
- ☐ ☐ Poor circulation
- ☐ ☐ Swollen Ankles
- ☐ ☐ Varicose Veins
- ☐ ☐ Chest Pain
- ☐ ☐ Shortness of Breath
- ☐ ☐ Asthma
- ☐ ☐ Other

Nervous System

Current/ Past

- ☐ ☐ Head Injury
- ☐ ☐ Dizziness
- ☐ ☐ Ringing in Ears
- ☐ ☐ Memory Loss
- ☐ ☐ Numbness
- ☐ ☐ Tingling
- ☐ ☐ Shooting Pain
- ☐ ☐ Depression
- ☐ ☐ Epilepsy
- ☐ ☐ Other

Muscles and Joints

Current/Past

- ☐ ☐ Rheumatoid Arthritis
- ☐ ☐ Osteoarthritis
- ☐ ☐ Osteoporosis
- ☐ ☐ Scoliosis
- ☐ ☐ Broken Bones
- ☐ ☐ Spinal Problems
- ☐ ☐ Lupus
- ☐ ☐ TMJ/jaw pain
- ☐ ☐ Spasms/Cramps
- ☐ ☐ Sprain/Strain
- ☐ ☐ Tendonitis
- ☐ ☐ Bursitis
- ☐ ☐ Stiff joints
- ☐ ☐ Painful joints
- ☐ ☐ Weak/sore muscles
- ☐ ☐ Neck, Shoulder, arm pain
- ☐ ☐ Low back, Hip, Leg Pain
- ☐ ☐ Other

Patient Signature________________

Date____________________