JOHN FRENCH MASSAGE THERAPY

HEALTH INFORMATION

PATIENT INFORMATION

Please Print Clearly Today's Date: _____

Name: _____

Gender: ❑Male ❑Female Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Referred By: _____

❑Home ❑Cell ❑ Work Phone: _____

❑Home ❑Cell ❑ Work Phone: _____

Occupation: _____

Employer: _____

If medically necessary do I have your permission to consult with your primary care physician,? ❑Yes ❑No

Primary Care Physician: _____

Primary Care Physician Phone Number: _____

Emergency Contact: _____

Emergency Contact Phone Number: _____

MASSAGE HISTORY/TREATMENT INFORMATION

Have you received a professional massage before? ❑Yes ❑No

If yes, frequency _____ Date of last massage _____

What results do you want from your massage session? _____

_____

_____

_____

Please check the areas of your body that you give permission to receive massage today:

❑Head ❑Face ❑Neck ❑Arms / Hands ❑Chest/Pecs

❑Abdomen ❑Back ❑Glutes / Hips ❑Legs / Feet

Please list in order of importance your areas of concern and symptoms.

_____

_____

_____

Are you currently working with and receiving treatment from a medical doctor or practitioner? If yes, please explain. ❑Yes ❑No

_____

_____

Are you currently seeing a psychotherapist or are you attending regular support group meetings? If yes, please explain. ❑Yes ❑No

_____

_____

List stress reduction and exercise activities. Include frequency.

_____

_____

List prescribed medications and over the counter drugs, dietary supplements (including vitamins and herbal supplements, etc) that you are currently taking.

_____

_____

_____

_____

HEALTH HISTORY

Please include date and treatment received for surgeries or accidents:

_____

_____

_____

Do you currently have any infectious diseases (i.e. cold, flu, HIV, hepatitis, etc) and if yes, please explain. ❑Yes ❑No

_____

_____

_____

Please check all current and previous conditions and explain

General

current past

- ❑ ❑ headaches
- ❑ ❑ sleep disorders
- ❑ ❑ fatigue
- ❑ ❑ infections
- ❑ ❑ fever
- ❑ ❑ sinus
- ❑ ❑ depression

Reproductive System

current past

- ❑ ❑ pregnancy
- ❑ ❑ pms
- ❑ ❑ fibrotic cysts
- ❑ ❑ other_____

Allergies

current past

- ❑ ❑ scents, oils or lotions
- ❑ ❑ detergents
- ❑ ❑ nuts
- ❑ ❑ other_____

Digestive / Elimination System

current past

- ❑ ❑ irritable bowel syndrome
- ❑ ❑ diverticulitus
- ❑ ❑ constipation
- ❑ ❑ diarrhea
- ❑ ❑ gas, bloating
- ❑ ❑ bladder / kidney / prostate
- ❑ ❑ abdominal pain
- ❑ ❑ other_____

Nervous System

current past

- ❑ ❑ head injuries, concussions
- ❑ ❑ dizziness, ringing in the ears
- ❑ ❑ loss of memory, confusion
- ❑ ❑ numbness, tingling
- ❑ ❑ sciatica, shooting pain
- ❑ ❑ chronic pain
- ❑ ❑ depression
- ❑ ❑ herpes / shingles
- ❑ ❑ other_____

Respiratory & Cardiovascular

current past

- ❑ ❑ heart disease
- ❑ ❑ blood clots
- ❑ ❑ stroke
- ❑ ❑ lymphadema
- ❑ ❑ high / low blood pressure
- ❑ ❑ irregular heart beat
- ❑ ❑ poor circulation
- ❑ ❑ swollen ankles
- ❑ ❑ varicose veins
- ❑ ❑ chest pain, shortness of breath
- ❑ ❑ asthma
- ❑ ❑ other_____

Cancer / Tumors

current past

- ❑ ❑ benign
- ❑ ❑ malignant

Endocrine System

current past

- ❑ ❑ thyroid
- ❑ ❑ diabetes
- ❑ ❑ other_____

Muscles and Joints

current past

- ❑ ❑ rheumatoid arthritis
- ❑ ❑ osteoarthritis
- ❑ ❑ osteoporosis
- ❑ ❑ scoliosis
- ❑ ❑ broken bones
- ❑ ❑ spinal problems
- ❑ ❑ disk problems
- ❑ ❑ lupus
- ❑ ❑ TMJ, jaw pain
- ❑ ❑ spasms, cramps
- ❑ ❑ sprains, strains
- ❑ ❑ tendonitis, bursitis
- ❑ ❑ stiff or painful joints
- ❑ ❑ weak or sore muscles
- ❑ ❑ neck, shoulder, arm pain
- ❑ ❑ low back, hip, leg pain
- ❑ ❑ other_____

Skin Conditions

current past

- ❑ ❑ rashes
- ❑ ❑ athlete's foot
- ❑ ❑ warts
- ❑ ❑ acne
- ❑ ❑ other_____

Habits

current past

- ❑ ❑ tobacco
- ❑ ❑ alcohol
- ❑ ❑ drugs
- ❑ ❑ coffee, soda
- ❑ ❑ caffeine
- ❑ ❑ eating disorders
- ❑ ❑ other_____

CONSENT FOR CARE

It is my choice to receive manual therapy and I give my consent to receive treatment. I understand that the massage I receive is provided for the purpose of stress reduction and the relief from muscular tension, spasm, or pain and to increase circulation/energy flow. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and or strokes may be adjusted to my level of comfort. I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. I have reported all health conditions that I am aware of and will inform the massage practitioner of any changes in my future health status. **Note**: Clients under the age of 18 must be accompanied by a parent or adult legal guardian during the entire session. Informed written consent must be provided by the parent or adult legal guardian on behalf of the minor.

Client/Guardian Signature: _____ Date: _____