ALLEGHENY MUSCLE THERAPY & MASSAGE **Health Information**

Please fill out the following information to the best of your ability. Please print clearly and legibly.

Contact Information:

Name: _____ Date: _____

Date of Birth: _____ Gender: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Is this a (mark one); Cell: _____ Work: _____ Home: _____

If cell phone, can you receive text messaging? _____ Cell Phone Provider (Ex: Verizon, AT&T): _____

E-mail: _____ Emergency Contact:_____

Would you like to receive our monthly Newsletters for specials and updates? _____

Emergency Contact Phone: _____ Emergency Contact Relationship: _____

How were you referred to us? _____

Practitioner Name: _____ Do you have a physician referral/prescription? Yes/No

Massage Information:

Have you ever received professional massage/bodywork before? Yes / No

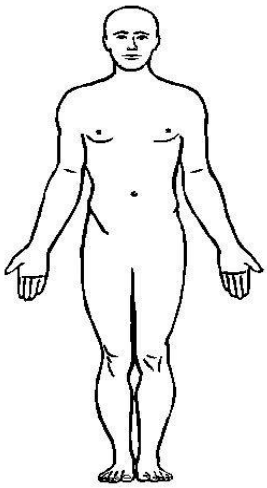
How recently?

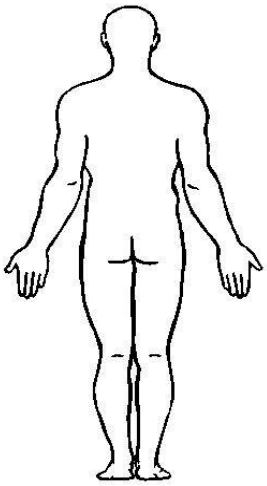
_____

What kind of pressure do you prefer?

Light Medium Firm

On the provided chart, please indicate any areas of symptoms you are experiencing. (Ex: pain, stress, stiffness, numbing, tingling, swelling, etc.)





Do any of these symptoms interfere with activities of daily living? (Ex: sleep, exercise, work, childcare, etc.) Please describe:

_____

_____

What are you expected goals/outcomes of your massage?

_____

_____

List any current medications:

_____

_____

List any allergies, including skin irritations (nuts, coconut oils, lotions, or any sensitivity).

_____

_____

Would you like any abdominal work? Yes / No

Have you recently had any injections or botox done? Yes / No

Please circle your answer:

Are you wearing contacts?	Yes / No	Are you pregnant?	Yes / No
Are you wearing dentures?	Yes / No		
Are you wearing a hairpiece?	Yes / No	How many weeks?	_____

Have you had any injuries, surgeries, or illness in the past that may influence today's treatment? If so, please describe:

_____

Please note if you have any of the following health conditions that you CURRENTLY have. If you are unsure, please ask your therapist: Blood clots, infections, congestive heart failure, contagious diseases, pitted edema, skin related issues (warts, open sores, bruising), fibromyalgia. YES / NO

Please indicate conditions that you have or have had in the past. If marked, please explain:

Current / Past Muscle or joint pain or stiffness: _____
Current / Past Numbness or tingling: _____
Current / Past Swelling: _____
Current / Past Bruise easily: _____
Current / Past Sensitive to touch/pressure: _____
Current / Past High/Low blood pressure: _____
Current / Past Stroke or heart attack: _____
Current / Past Varicose veins: _____
Current / Past Shortness of breath, asthma: _____
Current / Past Cancer: _____
Current / Past Neurological (Ex: MS, Parkinson's): _____
Current / Past Epilepsy, seizures: _____
Current / Past Headaches, migraines: _____
Current / Past Dizziness, ringing in the ears: _____
Current / Past Digestive conditions: _____
Current / Past Gas, bloating, constipation: _____
Current / Past Kidney disease, infection: _____
Current / Past Arthritis (rheumatoid, osteoarthritis): _____
Current / Past Osteoporosis, degenerative spine/disk: _____
Current / Past Scoliosis: _____
Current / Past Broken bones: _____
Current / Past Diabetes: _____
Current / Past Endocrine/thyroid conditions: _____
Current / Past Depression, anxiety: _____
Current / Past Memory loss, confusion, easily overwhelmed: _____

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the pressure and/or strokes may be adjusts to my level of comfort. I further understand that massage/bodywork should not be considered a substitute for medical examination, diagnosis, or treatment and that I should see a qualified medical specialist for certain conditions. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat and physical or mental illness, and nothing said in the course of treatment should be construed as such. Because massage/bodywork should not be performed under certain conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's fault should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advance made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____
Parent or Guardian Signature (If under 18): _____ Date:_____