Member #:_____ Therapist Name: _____

Name _____ ID#/DOB _____ Date _____

Phone _____ Address _____ Email _____

1. What are your goals for health, and how may I assist you in achieving your goals? _____

_____

2. List typical daily activities – work, exercise, home. _____

_____

3. Are you currently experiencing any of the following? If yes, please explain.

pain, tenderness ☐ No ☐ Yes _____ stiffness ☐ No ☐ Yes _____

numbness or tingling ☐ No ☐ Yes _____ swelling ☐ No ☐ Yes _____

allergies ☐ No ☐ Yes _____

4. List all illness, injuries and health concerns you have now or have had in the past 3 years.
(Examples: arthritis, diabetes, car crash, pregnancy) _____

_____

5. List medications and pain relievers taken this week. _____

6. I have provided all my known medical information. I acknowledge that massage therapy is not a substitute for medical diagnosis and treatment. I give my consent to receive treatment.

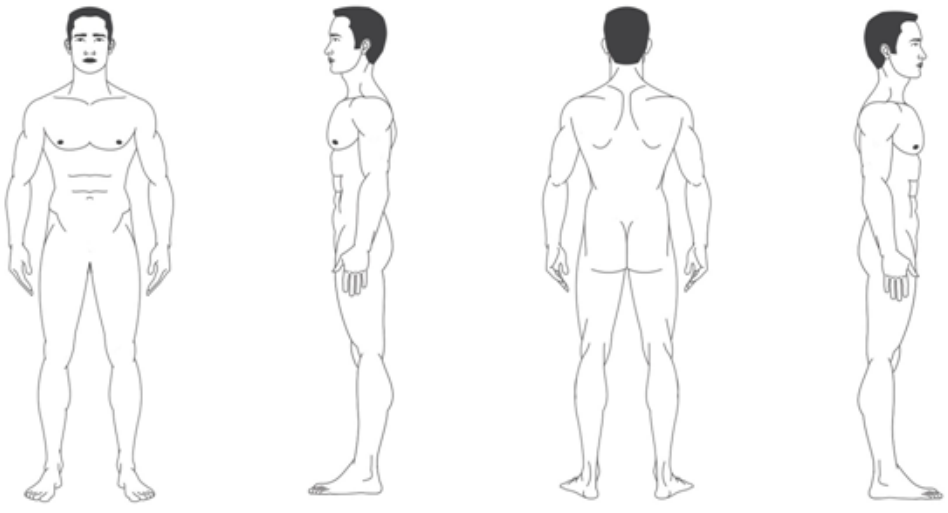
Signature _____ Date _____

Tx: _____

C: _____

Legend:

- TP
- TeP
- Ⓟ
- Infl
- HT
- SP
- Adh
- Numb
- rot
- elev
- Short
- Long



initials _____