INNERWAVES MASSAGE THERAPY

Name: _____ Date: _____
Address: _____
City: _____ State: ___ Zip: _____
Phone: Cell: _____ Home: _____
Occupation: _____ Email: _____
How did you hear about Innerwaves Massage Therapy?
Referred by: _____ Other: _____

Emergency Contact: Name: _____ Phone: _____
Prior massage therapy? __ Yes
Reason for your visit today? _____

How would you describe your general health?
__ Good __ Fair __ Poor

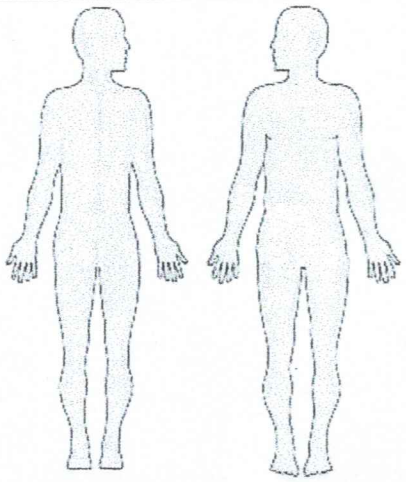
Regular exercise? __ Yes - Sleep well? __ Yes
Women – pregnant? __ Yes - Term? __

Symptoms/Conditions
C - Current P – Past F – Family history
__ Signs of inflammation or infection
__ Tension headaches or migraines
__ "Pins & needles" or numbness
__ Strength or sensory loss of any kind
__ Hearing of vision loss, balance/coordination
__ Cardiovascular disease. Pacemaker?
__ High or low blood pressure
__ Diabetes, or other hormone disorders
__ Broken bones, artificial joints, pins or plates
__ Osteo- or rheumatoid
__ Cuts, warts, open sores, skin irritation
__ Allergies, esp. nuts, Hypersensitive, anaphylaxis
__ Cancer or auto-immune disorder
__ Multiple sclerosis, epilepsy, nerve disorder
__ Other medical conditions not listed:
_____
Any surgeries or medical conditions that your therapist should know about: _____
_____
Areas that should be avoided during your massage?
_____
_____

Office use:
Therapist: _____
__ Detail entered in Booker
__ Document scanned into client profile

Please indicate your area of pain and number level of pain on chart.

No Pain
0
1
2
3
4
5
Severe



How do these symptoms affect your recreation, work and daily living?
_____
Are you receiving other therapies/treatments?
_____
Are you currently under the care of a doctor?
__ Yes Do we need to avoid any areas during the massage? __ Yes-- Area(s) to avoid..
_____

I understand:
My information is held private and confidential and only with my written permission will it be released.
The information that I have shared is correct and complete for treatment by a certified massage therapist.
Sign: _____ **Date:** _____