

ENDOCRINE SYSTEM:

THYROID DYSFUNCTION _____ DIABETES _____ HYPOGLYCEMIA _____

NERVOUS SYSTEM:

HEAD INJURIES/CONCUSSIONS _____ DIZZINESS/RINGING IN THE EARS _____ DEPRESSION _____

LOSS OF MEMORY/CONFUSION _____ NUMBNESS/TINGLING _____ SCIATICA/SHOOTING PAIN _____

CHRONIC PAIN _____ OTHER _____

MUSCLES AND JOINTS:

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 _____ OTHER _____

ANY OTHER AILMENT OR PHYSICAL CONCERNS NOT MENTIONED ABOVE _____

HEALTH HISTORY

LIST AND EXPLAIN, INCLUDING DATES AND TREATMENTS:

SURGERIES _____

ACCIDENTS _____

MAJOR ILLNESSES _____

WHAT ARE YOUR GOALS/EXPECTATIONS FOR THIS SESSION? PLEASE STATE

PHYSICIAN INFORMATION

NAME: _____ ADDRESS _____ CITY/STATE/ZIP _____

PHONE: _____ FAX: _____ E-MAIL ADDRESS _____

CONTRACT AND CONSENT FOR CARE

I, _____, understand that massage therapists do not diagnose medical, physical, or mental disorders, nor do they perform spinal manipulations by the use of thrusting force. I acknowledge that massage therapy is not a substitute for medical examination or treatment; massage therapy is complementary to medical services. I understand that the massage therapist may refuse to treat the undersigned if an existing medical problem is present and that the massage therapist can request a physician's written clearance before treatment may occur, because a massage therapist must be aware of any existing physical conditions. I have stated all my known conditions and take it upon myself to keep the massage therapist updated on my physical health.

SIGNATURE _____

DATE _____