Massage Therapy Works inc.

Health History Form

☐ Check this box if this is your first massage.

If no, when was your most recent massage? _____

Any allergies, such as nut-based oils? Which? _____

_____

Some of our therapists use essential oils. Are you scent sensitive? _____

Anything else you want us to know? _____

_____

_____

Please check off any of the following health conditions and note whether current or past:

☐ Arthritis: _____	☐ Heart Disease: _____	☐ Seizures: _____
☐ Asthma: _____	☐ High Blood Pressure: _____	☐ Severe Menstrual Cramps:
☐ Bursitis: _____	☐ Infections (current): _____	_____
☐ Cancer: _____	☐ Kidney Issue: _____	☐ Sinus Pressure: _____
☐ Concussion: _____	☐ Liver Issue: _____	☐ Skin Issue: _____
☐ Diabetes: _____	☐ Low Blood Pressure: _____	☐ Vertebral Issue: _____
☐ Digestive Disorders: _____	☐ Migraines: _____	☐ Whiplash: _____
☐ Dizziness: _____	☐ Nausea: _____	☐ Other: _____
☐ Headaches: _____	☐ Pins/Staples: _____	☐ Other: _____

Treatment Upgrade Authorization

Massage Therapy Works specializes in many levels of bodywork, each suited to different needs and goals of our clients. If you are dealing with a muscle strain from sitting all day in front of a computer, a recent injury, or a chronic pain, you are likely to see greater results with a clinically-focused approach such as *Integrative Bodywork*, *Deep Tissue Massage*, *Rehab Myotherapy or Biofield Tuning*.

If you chose a *Stress Reduction Massage*, please be aware that this is a soothing treatment using relatively light pressure and is not designed to resolve muscle tension issues such as knots and pain.

If you selected *Therapeutic Massage* for today's session and during the initial discussion your therapist feels that a more clinical approach would better achieve your goal of greater movement and less pain, you will have the option to upgrade to a different service.

Please select <u>one</u> of the following statements:

- ❑ I authorize my therapist to upgrade to whichever service they feel is most appropriate and in my best interest for achieving my goal. (NOTE: There will be an additional cost so please refer to our price list.)
- ❑ I think I prefer to stay with *Therapeutic Massage* at least for my first visit but I'm open to suggestion.
- ❑ At this time I am only interested in *Stress-Reduction Massage*, not deep pressure or clinical bodywork.

By signing I am acknowledging that I have filled out this form to the best of my ability and that the information I provided is accurate. I have read and agree to the **Terms and Conditions** including the **24-hour cancellation policy**.

_____ _____

Your Signature Date

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12/2016

Name: _____ Date of Birth: ____/____/____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ _____ _____ Is this a cell phone? (Y / N) Secondary Phone: _____ _____ _____

Email: _____ (For appt. confirmations, reminders & communication.)

☐ Please add me to your last-minute contact list for discounts and promotions via Email

How did you hear about us?

☐ Gift Certificate	☐ Outside Sign	☐ Doctor/ Chiropractor	☐ Friend/Family: _____ (full name)	☐ Google	☐ Yelp!	☐ Scout Magazine

Current Occupation: _____ Previous Occupation: _____

Current Exercise/Sports: _____ Previous Exercise/Sports: _____

Are you pregnant? How many weeks? _____

If so, any complications? _____

Rate your current stress level: 1 2 3 4 5

☐ Play(ed) musical instrument? Which? _____

☐ Stand still for 3+ hours a day?

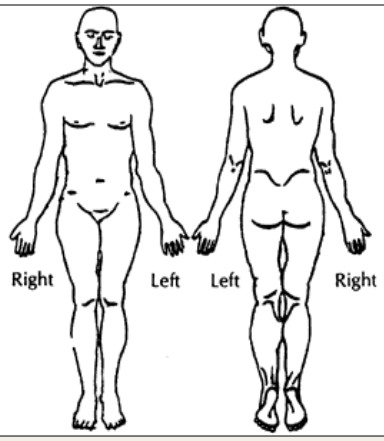
☐ Daily computer use? _____ Standing desk? _____

☐ Drive 2+ hours a day? _____ Ride to work? _____

Reason(s) for today's appointment?

☐ Need some Relaxation	☐ Stress/ Anxiety	☐ Chronic Pain	☐ Headaches/ Migraines	☐ Sports Injury	☐ Pre/Post Natal	☐ Post Surgery	☐ Other: _____
☐ Jaw Pain	☐ Neck Pain	☐ Shoulder Pain	☐ Back Pain	☐ Hip Pain	☐ Knee Pain	☐ Ankle/Foot Pain	☐ Wrist/Hand Pain

Describe all injuries and surgeries: _____



1. Circle your areas of pain
2. Put an X where you feel muscle tension
3. Put an N where you feel any numbness

Have you ever been in an automobile (or bicycle) accident? Were you injured? _____

Which areas of your body tighten up when you're active or stressed? _____

How would you describe your posture? _____

☐ Fine ☐ Not Great ☐ Horrible _____

Please turn over and fill out page 2