maryland licensed massage therapy

Massage Therapy Health Form

Date: _____

Name: _____ Date of Birth: _____

Address: _____

_____

Phone: (H) _____ (W) _____ (C) _____

E-mail: _____ How did you hear of us? _____

Names and ages of your children: _____

Are you currently under a physician's care? _____ If so, for what condition(s)? _____

_____

Name of physician: _____ Phone: _____

Consent to exchange information with your caregiver: (Initials) _____

Please list all medications and supplements you are currently taking: _____

_____

Please list all surgeries and/or injuries including approximate dates: _____

_____

Do you experience any difficulty lying on either your stomach or back? _____

If so, please specify: _____

Do you have any sensitivity to scented candles or oils? _____

Do you exercise regularly? _____ Please give a brief description including frequency and duration:

_____

Approximate number of hours of sleep per night: _____

Please rate the quality of your sleep on a scale of 1 to 5 (with 1 being extremely poor or broken sleep and 5 being restful sleep and waking refreshed): 1____ 2____ 3____ 4____ 5____

For female clients only: Is there any chance you are currently pregnant? ____

Please continue on reverse side →

Located in Complete Care Acupuncture and Wellness
1641 Crain Hwy #203, Crofton, MD 21114
410.530.3089 | www.mdlmt.com

Please check if you are currently experiencing or have any history of the following conditions:

Severe PMS____	Skin Rash____	Varicose Veins____
Painful Menses____	Open Sores____	Phlebitis____
Fluid Retention____	Abscess____	Arteriosclerosis____
Headaches____	IBS____	Hypertension____
Migraines____	Constipation____	Heart Disease____
Allergies____	Rheum. Arthritis____	Epilepsy____
Asthma____	Osteoarthritis____	HIV/AIDS____
Sinusitis____	Osteoporosis____	Cancer____
Inner Ear Problems____	Herniated Disc____	Diabetes____
TMJ Problems____	Sciatica____	Fibromyalgia____
Easy Bruising____	Limited ROM____	Anxiety____
Skin Sensitivity____	Carpal Tunnel Syn.____	Depression____

Details or any other relevant conditions: _____

_____

Do you currently have any areas of discomfort or pain?_____ If so, please describe: _____

_____

Please rate your recent stress level on a scale of 1 to 10 (with 1 being very low or manageable stress and 10 being very high or debilitating stress):

1____ 2____ 3____ 4____ 5____ 6____ 7____ 8____ 9____ 10____

What is your occupation:

Is this your first professional massage?_____ If not, when was your last massage? _____

What is your goal for today's session? _____

_____

Information on this form will be treated confidentially and will be reviewed by massage therapists rendering your therapy in order to provide quality service.

*** I take responsibility for alerting my massage therapist on subsequent visits of any changes in my health or physical condition that might affect this work.**

*** I understand that Massage Therapy is a form of complimentary and alternative medicine as defined by the National Institute of Medicine.**

*** I understand that if I cancel within 24 hours of my scheduled appointment I will be charged the full amount due.**

Signature: _____ Date: _____