All information you provide is strictly confidential and will become part of your medical record. **To Receive care this form must be completed and signed**

**Name** *(Last, First):* **Date of Birth:**

**Address:** **City:** **State:** **Zip**

**Cell Phone:** **Landline:** **E-mail:**

**Preferred Contact Method:** All/Any ☐ Text ☐ E-mail ☐

**Emergency Contact** **Contact Phone:**

**Primary Physician** **Date of Last Physical exam:**

**Medical**

Any medical conditions that are new (acute) or you always have (chronic)?:

Prescription/OTC Medications (It is important for massage):

**Surgeries**

| Year | Reason | Results |
|---|---|---|
| | | |
| | | |

**Other hospitalizations**

| Year | Reason | |
|---|---|---|
| | | |
| | | |

**Allergies**

| | Reaction You Had |
|---|---|
| | |

**HEALTH**

| | |
|---|---|
| **Exercise** | ☐ Sedentary (No exercise: due to medical condition or otherwise) |
| | ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, housecleaning, daily activities) |
| | ☐ Occasional vigorous exercise (i.e., work or recreation, less than 4 times a week for 30”) |
| | ☐ Regular vigorous exercise (i.e., work or recreation more than 4 times week for 30” or more) |
| | ☐ Extremely vigorous exercise (i.e., work or recreation 6 times a week for 30” or more) |
| **Competitive sports/hobbies** | |

**CHECK IF YOU HAVE, OR HAVE HAD, ANY SYMPTOMS IN THE FOLLOWING AREAS TO A SIGNIFICANT DEGREE AND BRIEFLY EXPLAIN**

| | | |
|---|---|---|
| ☐ Skin | ☐ Chest/Heart | ☐ Recent changes in weight: |
| ☐ Head/Neck | ☐ Back | ☐ Sexually Transmitted Disease |
| ☐ Ears | ☐ Intestinal | ☐ Low Energy level |
| ☐ Nose | ☐ Bladder | ☐ Sleep disorder(s) |
| ☐ Throat | ☐ Bowel | ☐ Pain/discomfort |

**What are your symptoms bringing you in for massage therapy?** **When did they begin?**

**Pain Scale 1 to 10** (1 = Little to none to 10=Worst Possible) **Today** **Best** **Worst**

How often do you feel these symptoms?

What makes them worse?

What makes them better?

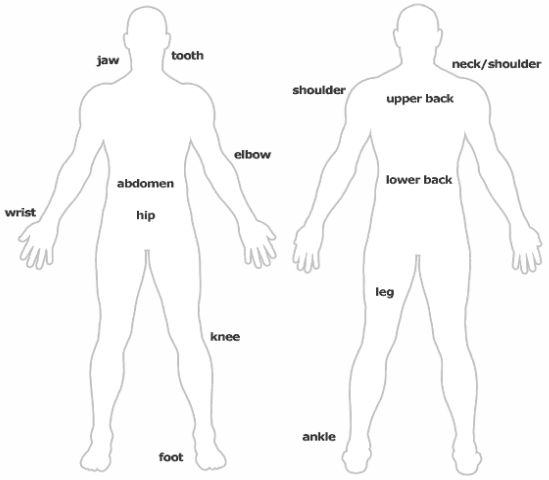
Who have you seen for these symptoms?

When and what treatment?

Test Performed and when?

Have you had similar symptoms in the past?

Shade areas where there is: discomfort / pain / Tenderness / tension / soreness / Restricted movements




**FRONT** **BACK**

| Massage Specific (optional) | | | | |
|---|---|---|---|---|
| Is stress a major problem for you? | ☐ | Yes | ☐ | No |
| Do you feel depressed? | ☐ | Yes | ☐ | No |
| Do you have trouble sleeping? | ☐ | Yes | ☐ | No |
| Do you suffer from back pain? | ☐ | Yes | ☐ | No |
| Do you get headaches? How many per week? | ☐ | Yes | ☐ | No |
| Any areas of swelling, or tendency to swell? | ☐ | Yes | ☐ | No |
| Any broken bones in the last two years | ☐ | Yes | ☐ | No |
| Do you have Arthritis? | ☐ | Yes | ☐ | No |
| Cancer or Tumors: | ☐ | Yes | ☐ | No |
| List any past or present skin conditions: | ☐ | Yes | ☐ | No |

I, (print name) _____ Consent for Treatment at Wellfit Massage, and I authorize the performance of massage therapy techniques and procedures by a licensed massage therapist in the State of Indiana. I understand the massage therapy given here is for general wellness purposes, including stress reduction, relief from muscular tension or spasm, promotion of circulation, lymph activity, and flexibility. Massage therapists do not diagnose illness, disease, or any other physical or mental disorder, do not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. I should see a doctor or other appropriate health care provider for diagnosis and treatment of any suspected medical problem. It is my responsibility to inform the massage therapist of any existing medical conditions I may have, and keep the massage therapist informed of any changes in my health and medications in the future. Massage therapy is contraindicated for certain medical conditions; I affirm that I have stated all my known medical conditions and answered questions pertinent to me on these 2 pages. I understand that potential risks of massage include: mild, short term muscle soreness due to movement of metabolic wastes; mild surface level bruising, and potential soreness. I have the right to refuse massage therapy treatment at any time during the session and the Massage Therapist has the same right to refuse treatment at any time for any reason. I understand this is a professional health care service facility, and any sexual requests, and/or advances towards a massage therapist, or any acts sexual in nature during a session will result it in immediate termination of the massage session, and law enforcement may be notified. I have read, completed and understand all forms and sign below in acknowledgement,

Signature: Date