

Complete the following for Therapeutic Massage

Have you ever received a professional massage: Yes No If Yes, how long ago: _____

What is your primary area of pain/discomfort: _____

When did you first notice this condition: _____

When is this condition most pronounced: AM PM Both

List any activities which aggravate this condition: _____

List any other areas of pain, concern or any additional information NOT listed previously, which may be relevant to your visit today: _____

Do you have any particular area(s) of your body you wish the Therapist to avoid? (Example: due to injury or sensitivity)

Please indicate all body conditions you have experienced. Mark **C** for current or **P** for past.

Joint/Soft Tissue Pain:

- | | | |
|---|---|---|
| <input type="checkbox"/> Arms | <input type="checkbox"/> Mid Back | <input type="checkbox"/> Knees |
| <input type="checkbox"/> Shoulders | <input type="checkbox"/> Lower Back | <input type="checkbox"/> Legs |
| <input type="checkbox"/> Joints: Which? _____ | <input type="checkbox"/> Degenerative Discs | <input type="checkbox"/> Neck |
| <input type="checkbox"/> Upper Back | <input type="checkbox"/> Feet | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Sciatica/Movement Limitation | <input type="checkbox"/> Hands | <input type="checkbox"/> Rheumatoid Arthritis |
| | <input type="checkbox"/> Hips | |
| | <input type="checkbox"/> Jaw | |

Cardiovascular:

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stroke / CVA | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Swelling of the Ankles |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Poor Circulation |

Skin:

- | | | |
|----------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Boils |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Dryness | <input type="checkbox"/> Other _____ |

General Symptoms:

- | | | |
|--|--|--|
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sudden Weight Loss/Gain | <input type="checkbox"/> Headaches (Tension) |
| <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Numbness | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Tingling | |

Infections:

- | | | |
|---------------------------------------|---------------------------------|---|
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Athlete's Foot |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cold | <input type="checkbox"/> Warts |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Flu | |

Digestive:

- Poor Appetite
- Belching/Gas
- Constipation

- Diarrhea
- Nausea
- Ulcer

- Vomiting

Eye, Ear, Nose, Throat:

- Allergies
- Frequent Colds

- Glasses or Contacts
- Hearing Aid/Loss

- Sinus Infection
- Swollen Glands

Reproductive: (*Females)

- Now Pregnant: Due _____?
- Painful Menstruation
- Heavy Flow

- Irregular Cycle
- Swollen Breasts
- Menopausal

- Premenopausal
- Postmenopausal
- Birth control, Type _____

Respiratory:

- Chronic Cough
- Bronchitis
- Asthma

- Hay Fever
- Difficulty Breathing
- Smoking

- Emphysema
- Pneumonia

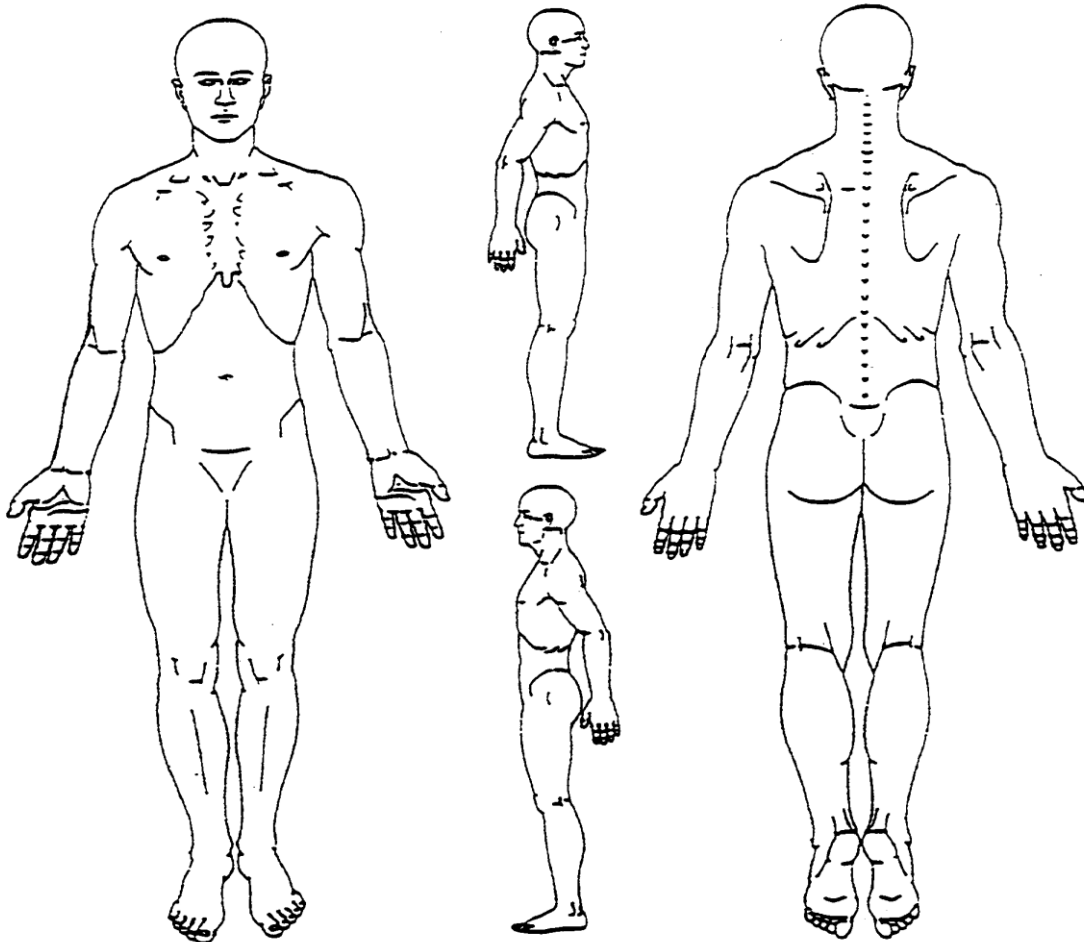
Other Conditions:

- Neurological Conditions
- Epilepsy
- Diabetes/Onset: _____
- Allergies _____
- Anaphylaxis: **YES/NO**
- Cancer _____

- Arthritis _____
- Type: OA/RA/Other: _____
- Vision Loss
- Hearing Loss
- Constipation
- Insomnia

- Hemophilia
- Kidney/Bladder Problems

Please mark any areas of discomfort with an X



Massage Therapy Acknowledgement

I have discussed all checked contraindications, if any, with the therapist for receiving a massage. I understand the massage I receive is provided for sole purpose of relaxation, stress reduction, relief of muscular tension, spasm or pain, or improvement of circulation. If I experience any pain or discomfort during this session, I will immediately inform the therapist so pressure and/or strokes may be adjusted to my level of comfort. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing discussed during session(s) given should be construed as such and massage therapy is contraindicated under certain medical conditions,

By my signature below, I certify and affirm that I have listed all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile, and understand that there shall be no liability on the therapist's part should I fail to do so.

Atlanta Colonic and Massage does not claim to treat or cure any condition, illness or disease.

Cancellations and Rescheduling:

We at Atlanta Colonic & Massage understand that sometimes a client may need to cancel or reschedule an appointment. We do require a minimum of a 24-hour notice for cancellations or rescheduling of appointments, to ensure therapist and facilities availability, for other clients. **No call/No shows will be charged 100% of total services scheduled for that day.**

I have read and understand Atlanta Colonic & Massage's cancellation/rescheduling policy.

Client Printed Name: _____
Last First MI

Client Signature: _____
(for clients under age of 18, signature of parent/legal guardian required) Date