


Angela Robertson
 MASSAGE THERAPY

Name: Last _____ First _____ M.I. _____ Date: _____
 Home address: _____ City: _____ State: _____ Zip Code: _____
 Daytime Phone: _____ Evening Phone: _____
 Occupation: _____ Date of Birth: _____
 Referred By: _____ Email Address: (for my use only) _____
 In Case Of Emergency, Contact: Last _____ First _____ Relationship _____
 Daytime Phone: _____ Evening Phone: _____

MEDICAL INFORMATION:

Have you ever been diagnosed with any of the following conditions?

(This information will assist me in knowing what techniques may not be appropriate)

- | | | |
|---|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> allergies | <input type="checkbox"/> low back pain |
| <input type="checkbox"/> cancer | <input type="checkbox"/> broken bone(s) | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> heart condition | <input type="checkbox"/> hemophilia | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> nerve damage | <input type="checkbox"/> pregnancy | <input type="checkbox"/> skin condition |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> HIV positive | <input type="checkbox"/> stroke |
| <input type="checkbox"/> spinal injury | <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> osteoporosis | <input type="checkbox"/> TMJ syndrome | <input type="checkbox"/> psychological diagnosis |
| <input type="checkbox"/> cystic fibrosis | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> asthma | <input type="checkbox"/> PMS syndrome |
| <input type="checkbox"/> headaches/migraines | <input type="checkbox"/> mid back pain | <input type="checkbox"/> neck pain |
| <input type="checkbox"/> carpal tunnel syndrome | <input type="checkbox"/> disc problem | <input type="checkbox"/> bursitis/tendonitis |
| <input type="checkbox"/> epilepsy, other seizure conditions | | |

Please describe any treatments you have been receiving to address your health conditions:
 (list any medications, surgeries, acupuncture, herbal treatments, ect.) Dates:

GENERAL INFORMATION:

YES NO

Have you previously received professional Soft Tissue Therapy?

By whom? _____

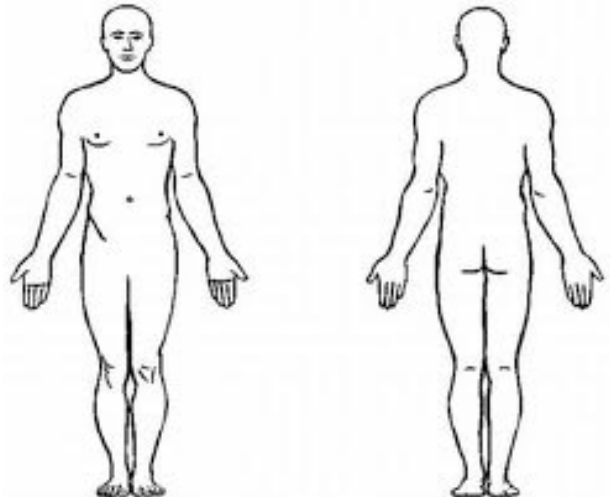
How long ago? _____

What kind? _____

Do you have any tension or soreness in a specific area? Explain _____

Are you sensitive to touch/pressure in any specific area? Explain _____

Mark the areas of Tension (T), Pain (P), Numbness (N), Chronic Condition (CC) and show path if pain radiates on your body.



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