Preferred
Massage Therapy

HEALTH FORM

Date: _____

Name: _____ Occupation: _____

Address: _____ City/Prov_____ Postal Code: _____

Home Phone: _____ Cell: _____

Email: _____ Date of Birth: _____

Emergency Contact: _____ Their Phone: _____

Is this your first professional massage? _____ If no, when did you receive your last massage?_____

What do you hope to accomplish from today's massage ____Relax? _____Pain Relief?

Are you aware of any tension holding spots in your body? Please list: _____

Describe any surgeries, hospitalizations, accidents or injuries you have had:

Less than 5 years ago: _____

More than 5 years ago: _____

What kinds of care did you receive for your accident or injury? _____

Do you feel that you have recovered from these events?____ Please explain: _____

_____

Do you have any chronic pain that you deal with on a regular basis?_____

Please list any medications that you are currently taking and what that medication is treating: _____

_____

Are you currently pregnant? _____ If so, how many months:_____

Do you have any allergies, especially to mint or cloves? _____

Do you smoke? _____ What's your stress level: (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Are there any other health concerns you wish to discuss today? If so, please explain:_____

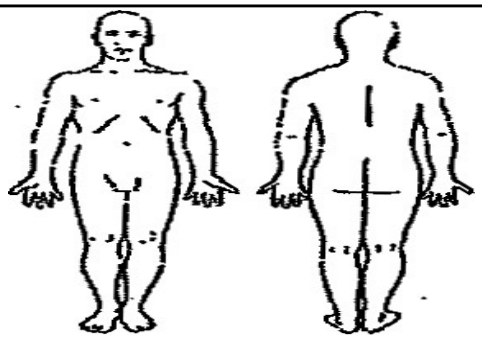
_____

Do you use any other modalities? ___ How often? _____ Acupuncture, Chiropractor, Physiotherapy, etc.?

Upper Chest (above breasts) | Abdomen | Back | Head | Legs | Feet | Arms | Buttocks

Please let us know if there are any areas listed above you would like us to avoid: _____

Please Circle on diagram below where the most tension or pain is in your body:



Please check any of the following conditions below that currently affect you or that you have experienced in the last 5 years.

Musculoskeletal:

- ☐ Fibromyalgia
- ☐ Spasms/Cramps
- ☐ Osteoporosis
- ☐ Postural Deviations
- ☐ Gout
- ☐ Osteoarthritis/Rheumatoid Arthritis
- ☐ TMJ
- ☐ Cysts
- ☐ Plantar Fasciitis
- ☐ Tendonitis
- ☐ Torticollis
- ☐ Whiplash Syndrome
- ☐ Carpal Tunnel Syndrome
- ☐ Sciatica
- ☐ Thoracic Outlet Syndrome
- ☐ Headache
- ☐ Leg Pain Right or Left?
- ☐ Arm/Shoulder pain Right or Left?
- ☐ Lower Back Pain
- ☐ Mid Back Pain
- ☐ Other: _____

Respiratory:

- ☐ Pneumonia
- ☐ Sinusitis
- ☐ Asthma
- ☐ Trouble Breathing
- ☐ Dizziness
- ☐ Other: _____

Circulatory:

- ☐ Anemia
- ☐ Hemophilia
- ☐ Hypertension
- ☐ Low Blood Pressure
- ☐ Raynaud's Disease
- ☐ Varicose Veins
- ☐ Heart Condition
- ☐ Blood Clots/Phlebitis
- ☐ Diabetes
- ☐ Other: _____

Digestive:

- ☐ Ulcers
- ☐ Irritable Bowel Syndrome
- ☐ Colitis
- ☐ Gallstones
- ☐ Hepatitis
- ☐ Cohn's Disease
- ☐ Diarrhea
- ☐ Gas/Bloating
- ☐ Indigestion
- ☐ Other: _____

Skin:

- ☐ Fungal Infections
- ☐ Acne
- ☐ Impetigo
- ☐ Dermatitis/Eczema
- ☐ Psoriasis

Skin (Continued):

- ☐ Open wound or sore
- ☐ Rashes
- ☐ Warts/Moles
- ☐ Athletes Foot
- ☐ Other: _____

Nervous System**:**

- ☐ ALS
- ☐ Multiple Sclerosis
- ☐ Parkinson's disease
- ☐ Bell's Palsy
- ☐ Neuritis
- ☐ Spinal Cord Injury
- ☐ Stroke
- ☐ Trigeminal Neuralgia
- ☐ Seizure Disorders
- ☐ Numbness/Tingling/Twitching
- ☐ Other_____

Skin:

- ☐ PMS
- ☐ HIV/AIDS
- ☐ Lupus
- ☐ Edema
- ☐ Cancer
- ☐ Pregnancy
- ☐ Grief Process
- ☐ Substance Abuse
- ☐ Other_____
- ☐ Chronic Fatigue
- ☐ Kidney Disease
- ☐ Bladder Infection
- ☐ Post-Operative
- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Insomnia

It is my choice to receive massage therapy. I realize that treatment is given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain or for the increase of circulation and energy flow. I agree to communicate with Gail Korpan anytime I feel like my well-being is being compromised. I understand I may be sore or stiff for a few days after receiving a massage. Gail Korpan reserves the right to refuse treatment if it is not recommended for the clients overall health.

I understand that massage practitioners do not diagnose illness, disease, physical or mental disorders nor do they prescribe medical treatment or pharmaceuticals. Massage practitioners do not perform Spinal Thrust manipulations. I understand and acknowledge that massage is not a substitute for medical examination or diagnosis. I have stated all medical conditions that I am aware of and will update my file if any changes in my health status occur.

SIGNATURE: DATE: