Patti Crimens
Licensed Massage Therapist

Health and Massage History

Name_____

Address_____

City_____ State_____ Zip_____

Email address_____

Home phone_____ Cell phone_____

Work phone_____ Birthdate_____

Occupation_____ ___Referred by_____

Have you ever received a professional massage? _____ (yes or no)

If yes, how often? _____ Date of last massage? _____

What results do you want from your massage sessions? _____
(relaxation, for example)

Please check areas of your body that you give permission to receive massage:

___back ___legs ___buttocks _____arms _____neck _____head _____face ___feet

Previous History: (include year and treatment received)

Surgeries:

_____

_____

Accidents:

_____

_____

List current medications, including aspirin, ibuprofen, etc._____

List stress reduction and exercise activities, including frequency:

_____

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List areas of TENSION, PAIN, or DISCOMFORT: _____

_____

Check any of the following that apply:

___bone or joint disease
___tendonitis
___bursitis
___arthritis
___sprains/strains
___low back, hip, leg pain
___neck, shoulder, arm pain
___headaches/head injuries
___spasms/cramps
___jaw pain/TMJ
___heart condition
___Varicose veins
___blood clots
___high blood pressure
___low blood pressure
___lymph edema
___breathing difficulty
___sinus problems
___allergies
___rashes
___athletes foot
___warts
___constipation
___diverticulitis
___irritable bowel syndrome
___herpes/shingles
___numbness/tingling
___chronic pain
___fatigue
___sleep disorders
___pregnant? ___stage
___PMS
___cancer/tumors
___diabetes
___eating disorders
___depression
___drug/alcohol addiction
___nicotine/caffeine addiction
___any contagious diseases _____
___any other pertinent information_____
_____

It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my mind and body. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner, Patti Crimens, any time I feel my well-being is being compromised.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update Patti Crimens, LMT with any changes in my health status.

I acknowledge Patti Crimens has a 24 hour notice on cancellations or payment will be requested.

Signature _____ Date _____