Massage Therapy Information
Red Lion Pain and Primary Care

Patient Information

First Name: _____ Last Name: _____

Date of Birth: ____/_____/_____ Gender: ❑ Male ❑ Female ❑ Other_____

Cell #:_____ Home Phone #: _____

Home Address: _____ City _____ State _____ Zip _____

E-Mail: _____ Soc. Security #: _____

Preferred way to reach you: ❑ Phone (voice) ❑ Phone (text) ❑

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Race: ❑ White ❑ African American ❑ Latin American ❑ Other _____

Emergency Contact: _____ Phone: _____ Relation: _____

Primary Care Physician: _____ *Address:* _____

How did you hear about our practice? _____

Massage Information

Have you ever had a professional massage before? □ Yes □ No
If yes, how often do you receive massage therapy? _____
If yes, do you have a style or pressure preference? □ Yes □ No
Specify: □ light pressure □ medium pressure □ deep pressure □ trigger point therapy
□ energy work □ Other _____
What type of massage are you seeking today? □ relaxation □ deep tissue/therapeutic □ pregnancy
□ senior □ integrated bodywork (functional) □ Other _____

Are you sensitive to fragrances or perfumes? □ Yes □ No
Do you have sensitive skin? □ Yes □ No Do you wear contact lenses? □ Yes □ No
Do you wear a hairpiece? □ Yes □ No Do you wear hearing aids? □ Yes □ No
What are the common areas of pain or tension? _____
_____

Do you suffer from chronic or persistent pain/discomfort? □ Yes □ No
If so, where? _____ and how long? _____
Do you see a chiropractor? □ Yes □ No If so, how often? _____
Are you currently under medical care? □ Yes □ No

Health History

Please check only those conditions which apply to you:

□ Abnormal Skin Condition		□ Neck Injuries	□ Stabbing Pain
□ Allergies	□ Fibromyalgia	□ Numbness	□ Tendonitis
□ Back Injuries	□ Headaches	□ Paralysis	□ TMJ Problems
□ Blood Clots	□ Heart Problem	□ Pregnancy	□ Tumors
□ Cancer	□ High / Low Blood Pressure	□ Recent Injury	□ Varicose Veins
□ Circulation Problem	□ Joint Replacement/Surgery	□ Sensitivities	□ Lack of/reduced feeling/sensation
□ Diabetes	□ Major Accident	□ Sprains/Strains	
□ Epilepsy / Seizures	□ Migraines	□ Other: _____	

Surgeries & Dates: _____

(Continued on reverse side)

Current Medications: _____

Current Condition

Please check any condition you are experiencing today:

□ Cold/Flu	□ Environmental Allergies	□ Skin Rash	□ Tension/Soreness
□ Fever	□ Contagious condition/disease	□ Open Cuts/Sores	□ Severe Pain
□ Injuries	□ Reaction to Skin Care Products	□ Warts	

Informed Consent and Massage Policies – PLEASE READ and SIGN BELOW

I understand that the massage I will be receiving here is for the purpose of stress reduction, relief from muscular tension or spasm. I understand that the massage therapist does not diagnose illness, disease or any further physical or mental disorders. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulations. I understand that massage is not a substitute for medical treatment or diagnoses and that it is recommended that I see a physician for any physical ailments that I may have.

I acknowledge that the information I have provided on this form is correct and current to the best of my knowledge. I understand that it is my responsibility to inform the massage therapist of any changes to this information. I understand that if I experience any unusual discomfort and/or pain during my massage sessions it is my responsibility to inform the massage therapist so that they can adjust the pressure or technique being used.

- ***For health and hygiene reasons, you will need to showered/bathed prior to your massage. No perfumes or fragrances should be applied prior to your massage.***
- ***Sexual remarks or advances will not be tolerated. If it occurs, the session will be terminated and you will be liable for payment, and denied future therapy.***
- ***Tipping, gifts, or payment directly to the massage therapist are not allowed.***
- ***If you are late for your massage, we will do our best to accommodate you without inconveniencing other patients who are on time. You will still be responsible to pay for the massage time that you scheduled.***

*****I understand that I am responsible for a fee of $35 if I cancel my appointment without giving 24-hour notice or NO SHOW for my apptoinemtn.*** Patient Initials: _____**

_____ _____

Signature of Patient (or Parent/Legal Guardian if a minor) *Date*

_____ _____

Print Name of Patient (or Parent/Legal Guardian if a minor) *Relationship to Patient*

_____ _____

Massage Therapist Signature Date