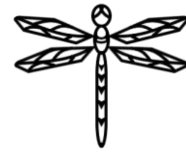
Date: / /

THE DRAGONFLY

MASSAGE AND BODYWORK THERAPY



Preferred Name: ______________________________________

Preferred Pronouns: ______________________________

First Name: ____

Date of Birth: ___________________________________

Last Name: ____

Referred by: ____________________________________

Email: ____

Phone #: ____

Address: ____

City: ____

State: ____

Zip Code: _______________________________________

Emergency Contact: ____________________________________

Relation to Emergency Contact: ____________________

Emergency Contact's Phone #: ___________________________

Physician's name: ______________________________________

Physician's phone #: _____________________________

Have you had a professional massage before?

◯ Yes (date of last treatment) ___________________________

◯ No

How would you rate your general health?

◯ Excellent ◯ Good

◯ Fair ◯ Poor

List current medications & the conditions they treat:

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List any major accidents or surgeries (include dates):

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List any allergies or hypersensitivities:

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Reason for initial visit:

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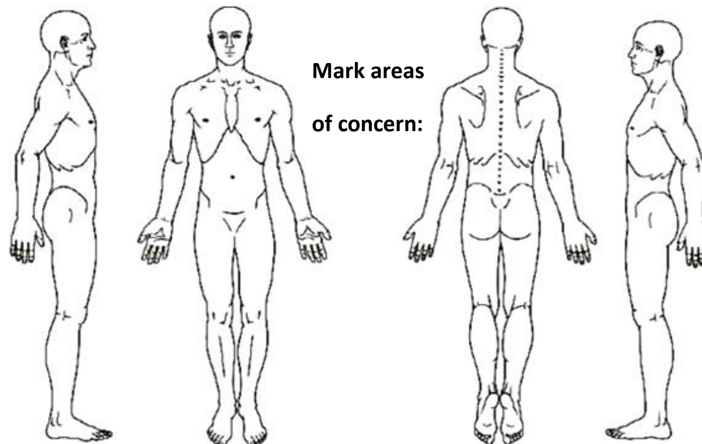

Mark areas of concern:

HEAD / NECK

◯ Headaches / migraines ◯ Vertigo / dizziness ◯ Ringing in ears ◯ Hearing loss ◯ Vision problems ◯ Vision Loss

CARDIOVASCULAR

◯ High Blood Pressure ◯ Low Blood Pressure ◯ Heart Attack ◯ Stroke ◯ Heart Disease ◯ Poor Circulation ◯ Pacemaker

◯ Phlebitis / varicose veins ◯ Hemophilia ◯ Congestive heart failure ◯ Family history of cardiovascular problems

RESPIRATORY

◯ Asthma ◯ Shortness of breath ◯ Chronic cough ◯ Bronchitis ◯ Emphysema ◯ Sinusitis ◯ Smoker ◯ Frequent Colds

◯ Family history of respiratory difficulties

NERVOUS SYSTEM

◯ Numbness / tingling ◯ Sensory loss / change ◯ Sciatica ◯ Epilepsy ◯ Seizures ◯ Multiple sclerosis

SKIN & INFECTIONS

◯ Hepatitis ◯ HIV / AIDS ◯ Herpes ◯ Tuberculosis ◯ Lyme Disease ◯ Infectious skin conditions

MUSCULOSKELETAL SYSTEM

◯ Arthritis ◯ Family history of arthritis ◯ Osteoporosis ◯ Tendonitis ◯ Bursitis ◯ Jaw pain (TMJ)

◯ Pins / plates / wires / artificial joint

REPRODUCTIVE

◯ Pregnant ◯ Given birth ◯ Gynecological problems

OTHER CONDITIONS

◯ Digestive Conditions ◯ Unexplained weight loss ◯ Cancer ◯ Diabetes ◯ Fibromyalgia ◯ Chronic fatigue syndrome

◯ Depression ◯ Anxiety ◯ Psychiatric disorder ◯ Other conditions ____

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It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I understand that my person health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

Treatment may be covered by extended health care plans. I understand that it is my responsibility to confirm the exact details of my coverage.

Signature: ____ Date: ______________________

◯ Reviewed _______________