9 Bloomfield Ave., Denville, NJ
973-219-2476

Health Information

Client Contact Information Date ___________________

Client Name: ____ Date of Birth: ____________________ Gender: ___________

Address: ____

Phone: _______________________________________ Email: ____

Referred by: ____

Emergency contact: ____ Phone: ______________________________________

Physician/Health-care Provider name: ______________________________ Phone: ______________________________________

Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes ☐ No ☐

Do you have a physician referral/prescription? Yes ☐ No ☐

Are you seeking insurance reimbursement? Yes ☐ No ☐ If yes, please complete the Billing Information form.

Type of insurance coverage for this claim: Car Collision Worker's Compensation Private Health

Medical Massage Information

Have you ever received professional massage/bodywork or medical massage before? Yes ☐ No ☐ How recently? _____________

How do you feel today? ____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

____

____

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes ☐ No ☐

Explain: ____

____

List the medications you currently take:

____

____

Are you wearing contacts? Yes ☐ No ☐

Are you wearing dentures? Yes ☐ No ☐

Are you wearing a hairpiece? Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐

9 Bloomfield Ave., Denville, NJ
973-219-2476

Health Information

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment?

____

Circle any of the following health conditions that you currently have (If you are unsure, please ask):

blood clots, infections, congestive heart failure, contagious diseases, pitted edema

Please answer honestly, as massage may not be indicated for the above conditions.

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

Current Past Muscle or joint pain ______________________________

Current Past Muscle or joint stiffness ______________________________

Current Past Numbness or tingling ______________________________

Current Past Swelling ______________________________

Current Past Bruise easily ______________________________

Current Past Sensitive to touch/pressure ______________________________

Current Past High/Low blood pressure ______________________________

Current Past Stroke, heart attack ______________________________

Current Past Varicose veins ______________________________

Current Past Shortness of breath, asthma ______________________________

Current Past Cancer ______________________________

Current Past Neurological (e.g. MS, Parkinson's, chronic pain) ______________________________

Current Past Epilepsy, seizures ______________________________

Current Past Headaches, Migraines ______________________________

Current Past Dizziness, ringing in the ears ______________________________

Current Past Digestive conditions (e.g. Crohn's, IBS) ______________________________

Current Past Gas, bloating, constipation ______________________________

Current Past Kidney disease, infection ______________________________

Current Past Arthritis (rheumatoid, osteoarthritis) ______________________________

Current Past Osteoporosis, degenerative spine/disk ______________________________

Current Past Scoliosis ______________________________

Current Past Broken bones ______________________________

Current Past Allergies ______________________________

Current Past Diabetes ______________________________

Current Past Endocrine/thyroid conditions ______________________________

Current Past Depression, anxiety ______________________________

Current Past Memory Loss, confusion, easily overwhelmed ______________________________

Comments: ____

____

9 Bloomfield Ave., Denville, NJ
973-219-2476

Health Information

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the treatment may be adjusted. I further understand that medical massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that medical massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because medical massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: ____ Date: ________________

Parent or Guardian Signature (in case of a minor): ____________________________________ Date: ________________