

# Brandon Natural Care Center, P.C.

## Massage Therapy Patient Information

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Age \_\_\_\_\_  
DOB \_\_\_\_\_ Referred by: \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer \_\_\_\_\_ Physician \_\_\_\_\_ Medications/Supplements: \_\_\_\_\_

Primary Reason for Appointment \_\_\_\_\_

PLEASE ANSWER THE FOLLOWING QUESTIONS (EXPLAIN YES ANSWERS BELOW):

Have you ever had a professional massage before?	Yes	No	
Have you ever had surgery?	Yes	No	
Do you have any spinal problems?	Yes	No	
Are you pregnant?	Yes	No	Not sure
Do you have chronic back pain?	Yes	No	
Do you get frequent headaches?	Yes	No	
Have you ever had seizures?	Yes	No	
Do you have HIV/Diabetes/Cancer?	Yes	No	
Are you frequently tired?	Yes	No	
Do you have any heart problems?	Yes	No	
Do you have high blood pressure?	Yes	No	
Do you have varicose veins?	Yes	No	
Do you bruise easily?	Yes	No	
Do you have blood clots?	Yes	No	
Do you have arthritis?	Yes	No	
Do you have burns/scar tissue?	Yes	No	
Have you suffered an acute injury?	Yes	No	
Do you suffer from tension?	Yes	No	
Do you have pain which radiates down your arms/legs?	Yes	No	
Have you ever had cosmetic surgery?	Yes	No	
Do you have any allergies?	Yes	No	

Please explain YES answers \_\_\_\_\_

Do you have any other medical condition that we should be aware of? Yes No  
If yes, please explain \_\_\_\_\_

I understand that the massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation. I understand that the massage therapist does not diagnose illness, disease, or any physical or mental disorder. As such, the massage therapist prescribes neither medical treatment nor pharmaceuticals, nor performs any spinal manipulations. It has been made very clear to me that massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have. Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions, and if there are any changes to my health status, I agree to inform the massage therapist immediately.

Signature \_\_\_\_\_ Date \_\_\_\_\_