The Healing Garden
mend the body, nurture the soul

Massage Consultation

Name: Date:

What is the reason for today's visit?

How would you rate your pain? Scale: **0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10**

What makes it better? What makes it worse?

Are you currently being treated or have you ever received treatment for this condition? **YES NO**

Are you seeing an MD, OD, Chiropractor or Physical Therapist? **YES NO** If yes, who?

Is this a PIP auto accident claim? **YES NO**

What activities do you spend most of your day doing? Sitting Standing Walking Bending Heavy labor

How often do you exercise? What type?

Do you have (or have you ever had) any major medical issues? (Please list all)

Injuries/Trauma?

Auto Accidents?

Surgery?

Broken Bones?

Are you Pregnant? **YES NO**

If yes, please initial to verify that your doctor has approved massage therapy for you _____

IMPORTANT: ***Do you currently have (or have you ever had) any of the following:***

Blood Clots	**Cancer**
MRSA	**Aneurism**
Stroke	**Fractures to the Neck or Back**
Osteoporosis/Osteopenia	**Any contagious condition**

Please list all medications and supplements:

Do you take medications that thin the blood? YES NO

Are you taking any sensation-altering medication? YES NO

Please list all allergies or sensitivities:

Have you ever received Massage Therapy before? **YES NO** If so when was your last treatment?

Do you have a preference in type of massage or pressure?

Do you have any special considerations you wish us to be aware of?

I understand that massage is given here for the purpose of stress reduction, relief from muscular tension, spasm and/or pain and for increasing circulation/energy flow.

I understand that the massage practitioner does not diagnose illness, disease or any other physical or mental disorder. As such, the massage practitioner does not prescribe medical treatment or pharmaceutical nor does she perform spinal manipulations. It has been made clear that massage is not a substitute for medical examination or diagnosis and it is recommended that I see a physician for any physical ailment that I might have.

I have stated all my known medical conditions and take full responsibility to keep the massage practitioner updated on my physical health.

Signature: _____ Date: _____

Print Name: _____

Parent/Guardian Signature: _____ Date: _____