Massage Update Form

Patient Information

Date______________________

Patient____

Address (if Changed)________________________________

____
City State Zip

Home Phone ______________________________

Work/Cell Phone ______________________________

Accident Information

Is condition due to an accident? ❑ Yes ❑ No Date____

Type of accident ❑ Auto ❑ Work ❑ Home ❑ Other

To whom have you made a report of your accident?

❑ Auto Insurance ❑ Employer ❑ Worker Comp. ❑ Other

Attorney Name (if applicable)______________________

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Client Condition

When did your symptoms begin?____

What treatment have you already received for your condition?

❑ Medication ❑ Surgery ❑ Physical Therapy ❑ Chiropractic Care ❑ None ❑ Other

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

How often do you have this pain?____________________ Is it constant or does it come and go?__________________

Does it interfere with your ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Activities or movements that are painful to perform ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down

Massage History

Have you ever received a professional massage? ❑ Yes ❑ No

Why did you come for our service? ❑ Relaxation ❑ Pain ❑ Therapy ❑ Other____________________________

What results would you like to acheive?____

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Prioritize the areas of your body that you wish to be massaged. Please note any areas of your body that you **prefer not to be** massaged.

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Authorization

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that is my responsibility to inform my healthcare provider if I ever have a change in health.

I understand that massage therapy services are for the primary purpose of short-term relaxation and the relief of muscular tension. I understand that massage therapy services are in no way a substitute for examination, diagnosis, or treatment by a physician. I understand that individuals providing massage therapy services are not qualified to diagnose, prescribe, or treat any physical or mental illness and are not qualified to perform spinal or skeletal adjustments. I acknowledge that any information I receive from individuals performing massage therapy services is educational in nature and is to be used at my own discretion.

____ ______________________
Signature of Patient, Parent, Guardian or personal Representative Date

____ ______________________
Please Print Name of Patient, Parent, Guardian or personal Representative Date