— SPINE & SPORT —

Name: _____ **Gender**: □ M □ F **Date of Birth**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Cell Phone: _____ **Email**: _____

In case of emergency: _____ **Phone**: _____

General & Medical Information

□ Yes □ No Have you ever had a professional massage?
When was your last session? _____

□ Yes □ No Do you experience frequent headaches?
What makes it better? _____ Worse? _____

□ Yes □ No Are you pregnant? How far along are you? _____

□ Yes □ No Are you diabetic? Are you taking meds for this? □ Yes □ No

□ Yes □ No Do you have high or low blood pressure? Are you taking meds for this? □ Yes □ No

□ Yes □ No Do you suffer from seizure disorders? Are you taking meds for this? □ Yes □ No

□ Yes □ No Do you suffer from frequent stress?
What makes it better? _____ Worse? _____

□ Yes □ No Have you had any injuries or surgeries in the past two years?
When? _____ Still under MD care? □ Yes □ No

□ Yes □ No Have you had any broken bones in the past two years?
Where? _____ Date of Injury: _____

□ Yes □ No Are you sensitive to touch/pressure in any area?
What type of pressure do you prefer? □ Light □ Medium □Deep
Light (superficial/skin) Medium (firm into the muscle) Deep (hard/to the bone)

□ Yes □ No Do you have tension or soreness in a specific area?
Where? _____
What makes it better? _____ Worse? _____

□ Yes □ No Do you have cardiac or circulatory problems?
List: _____

□ Yes □ No Do you suffer from back pain?
What makes it better? _____ Worse? _____

□ Yes □ No Do you have numbness or stabbing pains anywhere?
What makes it better? _____ Worse? _____

□ Yes □ No Do you suffer from arthritis? What Type? _____
List Meds: _____

□ Yes □ No Do you have allergies?
To what? _____

□ Yes □ No Do you bruise easily?
On blood thinners? □ Yes □ No