FITNESS FOR HER Synergy

MASSAGE THERAPY FORM

PERSONAL INFORMATION

Full Name

E-mail Address

Date Of Birth ____ / ____ / ____ **Phone Number** ____

Emergency Contact ____ **Relationship** ____

Phone 1 ____ **Phone 2** ____

Address

Physician's Name ____ **Phone** ____

Medications and What They Treat

Have you had a massage before? ☐ Yes (Date of last treatment) ____ ☐ No

How would you rate your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Any allergies or sensitivities?

Any major accidents or surgeries?

Head/Neck

☐ Headaches/ Migraines ☐ Vertigo/ Dizziness ☐ Hearing Loss
☐ Vision Loss ☐ Ringing in Ears ☐ Vision Problems

Respiratory

☐ Asthma ☐ Shortness of Breath ☐ Smoker
☐ Emphysema ☐ Sinusitis ☐ Chronic Cough
☐ Bronchitis ☐ Family history of respiratory difficulties

Cardiovascular

☐ High Blood Pressure ☐ Low Blood Pressure ☐ Heart Attack
☐ Stroke ☐ Heart Disease ☐ Poor Circulation
☐ Phlebitis/ Varicose Veins ☐ Pacemaker ☐ Bruises/ Bleeds Easily
☐ Chronic Congestive Heart Failure
☐ Family history of cardiovascular problems

Nervous System

☐ Sensory Loss/ Change ☐ Epilepsy ☐ Seizures
☐ Numbness/ Tingling ☐ Multiple Sclerosis ☐ Sciatica

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MASSAGE THERAPY FORM

Full Name

Musculoskeletal System

- ☐ Arthritis
- ☐ Burstitis
- ☐ Osteoporosis
- ☐ Jaw Pain (TMJ)
- ☐ Tendonitis
- ☐ Pins/Plates/Wires / Artificial Joint

Skin & Infections

- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ HIV/AIDS
- ☐ Lyme Disease
- ☐ Herpes
- ☐ Infectious Skin Condition

Reproductive

- ☐ Pregnant
- ☐ Recently Given Birth
- ☐ Gynecological Problems

Other

- ☐ Cancer
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Conditions
- ☐ Anxiety
- ☐ Unexplained Weight Loss
- ☐ Chronic Fatigue Syndrome
- ☐ Psychiatric Disorder
- ☐ Other Conditions:

INFORMED CONSENT AND LIABILITY RELEASE

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law.

I affirm that I have read this form in its entirety and understand its contents. I also affirm that all of my questions have been answered to my satisfaction.

Signature _____ **Date** _____

OFFICE USE ONLY

High Risk Conditions? _____ **Alert Added in Fit Degree** ☐

Notes _____

_____

Date Revised: 3/17/2022