Nora Avenue

Massage and Therapies

Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail: _____ Date of Birth: _____

Occupation: _____

Physician's Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Have you ever had Massage Therapy before? ☐ Yes ☐ No

Are you currently under a Doctor's, Chiropractor's or Physical Therapist's care? ☐ Yes ☐ No

If **YES**, for what condition? _____

Do we have permission to contact your doctor on the advisability of massage? ☐ Yes ☐ No

How did you discover this service? _____

Please list any medications you are taking: _____

Please mark with an (X) all conditions that apply. Mark (P) for past conditions and indicate how many years ago.

☐ tension headaches	____	☐ whiplash	____	☐ congestive heart failure	____
☐ migraines	____	☐ osteoarthritis	____	☐ rheumatoid arthritis	____
☐ varicose veins	____	☐ cancer	____	☐ circulatory problems	____
☐ stroke	____	☐ disc problems	____	☐ spinal fusions	____
☐ osteoporosis	____	☐ recent surgery	____	☐ infectious disease	____
☐ diabetes	____	☐ recent injury	____	☐ high/low blood pressure	____
☐ fibromyalgia	____	☐ heart attack		☐ hip/knee replacement	____
☐ jaw pain/TMJ	____	☐ allergies to nut based oils/lotions	____		

Please explain any conditions noted above *or if you have any other conditions not listed.*

_____

_____

_____

I have completed the above information to the best of my knowledge. I understand that massage therapy does not replace a physician's care. I understand that the therapist may refuse massage due to certain medical contraindications, unless the treating physician advises us in writing that massage will be beneficial. I understand that the therapist also reserves the right to refuse or discontinue massage due to unethical behavior or misconduct.

Signature: _____ Date: _____