

Deb Levesque Massage Therapy

MEDICAL HISTORY

Name: _____

Mailing address: _____

Town: _____ State: _____ Zip code: _____

Date of Birth: _____ Occupation: _____

Home phone #: _____

Other phone #: _____

Which phone is best to reach you to leave a message? Home or Other

Primary Care Physician: _____

Date of Last Physical: _____

MEDICATIONS:

REASON FOR TAKING . . .

Please circle if you have (or had) a problem in any of these areas:

Allergies

Arthritis

Bleed or bruise easily

Blood Pressure Problems

Bursitis

Cancer

Depression

Diabetes

Epilepsy

Headaches

Heart Disease

Hernia

Joint Problems

Pregnancy

Skin Problems

Smoker

Stomach Ulcers

Varicose Veins

Vertebral Problems

Other: Please indicate any recent accidents, traumas, and / or any other information that is pertinent to your health status

How were you referred to this office? _____

Have you received massage in the past? YES / NO

What is your reason for choosing massage today?

____ Relaxation / stress relief ____ Sport or work injury ____ Muscle tension or spasm

____ Gift certificate ____ Other _____

What are your exercise habits? _____

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Massage Therapy Informed Consent

YES / NO I understand that massage therapy is intended to enhance relaxation, reduce pain, increase range of motion, improve circulation and offer a positive experience to touch.

YES / NO I understand that massage therapy is not a substitute for medical treatment or medication, and it is recommended that I concurrently work with my Primary Care Provider for any conditions I may have.

YES / NO I understand that a massage therapist does not diagnose illness or disease, prescribe medication, or use spinal manipulations.

YES / NO I have informed the massage therapist of all my known physical conditions, medical conditions and medications. When any conditions change, I will update the massage therapist.

Missed Appointments

Unless appointments are cancelled 24 hours in advance, you will be charged full price for the missed treatment. You may call and leave a voice message at any time.

Your signature indicates that you understand this policy. _____
Date: _____

Please mark the drawings below where you have pain or tension.

