**Deb Levesque Massage Therapy**
MEDICAL HISTORY

Name: _____
Mailing address: _____
Town: _____ State: _____ Zip code: _____
Date of Birth: _____ Occupation: _____
Email address (for online scheduling / newsletter): _____

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

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
Currently Pregnant
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? _____

**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.

**Late Policy** If the client is late, the appointment will be shortened and end according to the original start time of the appointment. The client will be charged the full treatment fee.

**Missed Appointments** Your treatment time is reserved specifically for you. Please provide a minimum of 24 hours' notice to cancel an appointment. Clients who do not call within 24 hours will be charged the full appointment fee. Voice mail is accessible 24 hours/day. Emergency cancelations are assessed on a case by case basis.

Your signature indicates that you understand this policy._____

Date: _____

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