

SYNERGY MASSAGE & WELLNESS CENTER HEALTH INFORMATION

Client Name _____ Date _____

A. Client Information

Address _____
City/State/Zip _____
Phone: Home (____) _____ - _____
Work (____) _____ - _____ Cell (____) _____ - _____

Date of Birth _____

Height _____

Employer _____
Work Address _____
Occupation _____
Emergency Contact _____
Phone: Home (____) _____ - _____
Work (____) _____ - _____ Cell (____) _____ - _____

Weight – please check

Under 250 lbs

Over 250 lbs

Have you received massage therapy before?
Frequency? _____

Primary Health Care Provider _____
Address _____
City/State/Zip _____
Phone: _____ Fax: _____

What are your goals for receiving massage therapy?

I give my massage therapist permission to consult with my health care providers regarding my health and treatment.
Comments _____
Initials _____ Date: _____

B. Current Health Information

List Health Concerns. Check all that apply

Primary N/A _____

- mild moderate disabling
 - constant intermittent
 - symptoms ↑ w/activity ↓ w/activity
 - getting worse getting better no change
- treatment received _____

Secondary N/A _____

- mild moderate disabling
 - constant intermittent
 - symptoms ↑ w/activity ↓ w/activity
 - getting worse getting better no change
- treatment received _____

Additional N/A _____

- mild moderate disabling
 - constant intermittent
 - symptoms ↑ w/activity ↓ w/activity
 - getting worse getting better no change
- treatment received _____

C. Health History

List and explain. Include dates and treatment received.

Surgeries N/A _____

Injuries N/A _____

Major illnesses N/A _____

List Current Medication & Herbal Remedies
Medication Condition used for

PLEASE COMPLETE THE OTHER SIDE

**PLEASE CHECK ALL CURRENT AND PREVIOUS CONDITIONS
& LIST SPECIFIC MEDICATIONS**

| <p align="center">GENERAL</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:15%;">Current</th> <th style="width:15%;">Past</th> <th style="width:70%;">Medication</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>headaches_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>pain_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>sleep disorders_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>fatigue_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>infections_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>fever_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>sinus_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>other_____</td></tr> </tbody> </table> | Current | Past | Medication | <input type="checkbox"/> | <input type="checkbox"/> | headaches_____ | <input type="checkbox"/> | <input type="checkbox"/> | pain_____ | <input type="checkbox"/> | <input type="checkbox"/> | sleep disorders_____ | <input type="checkbox"/> | <input type="checkbox"/> | fatigue_____ | <input type="checkbox"/> | <input type="checkbox"/> | infections_____ | <input type="checkbox"/> | <input type="checkbox"/> | fever_____ | <input type="checkbox"/> | <input type="checkbox"/> | sinus_____ | <input type="checkbox"/> | <input type="checkbox"/> | other_____ | <p align="center">NERVOUS SYSTEM</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:15%;">Current</th> <th style="width:15%;">Past</th> <th style="width:70%;">Medication</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>head injuries_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Concussions_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>loss memory/confusion_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>dizziness_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>ringing in ears_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>sciatica shooting pain_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>chronic pain_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>depression_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>numbness, tingling_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>other_____</td></tr> </tbody> </table> | Current | Past | Medication | <input type="checkbox"/> | <input type="checkbox"/> | head injuries_____ | <input type="checkbox"/> | <input type="checkbox"/> | Concussions_____ | <input type="checkbox"/> | <input type="checkbox"/> | loss memory/confusion_____ | <input type="checkbox"/> | <input type="checkbox"/> | dizziness_____ | <input type="checkbox"/> | <input type="checkbox"/> | ringing in ears_____ | <input type="checkbox"/> | <input type="checkbox"/> | sciatica shooting pain_____ | <input type="checkbox"/> | <input type="checkbox"/> | chronic pain_____ | <input type="checkbox"/> | <input type="checkbox"/> | depression_____ | <input type="checkbox"/> | <input type="checkbox"/> | numbness, tingling_____ | <input type="checkbox"/> | <input type="checkbox"/> | other_____ | <p align="center">ALLERGIES</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:15%;">Current</th> <th style="width:15%;">Past</th> <th style="width:70%;">Medication</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>scents, oils_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>lotions_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>detergents_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>other_____</td></tr> </tbody> </table> | Current | Past | Medication | <input type="checkbox"/> | <input type="checkbox"/> | scents, oils_____ | <input type="checkbox"/> | <input type="checkbox"/> | lotions_____ | <input type="checkbox"/> | <input type="checkbox"/> | detergents_____ | <input type="checkbox"/> | <input type="checkbox"/> | other_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Current | Past | Medication | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | headaches_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | pain_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | sleep disorders_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | fatigue_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | infections_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | fever_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | sinus_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | other_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Current | Past | Medication | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | head injuries_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Concussions_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | loss memory/confusion_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | dizziness_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | ringing in ears_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | sciatica shooting pain_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | chronic pain_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | depression_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | numbness, tingling_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | other_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Current | Past | Medication | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | scents, oils_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | lotions_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | detergents_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | other_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p align="center">MUSCLES AND JOINTS</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:15%;">Current</th> <th style="width:15%;">Past</th> <th style="width:70%;">Medication</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>rheumatoid arthritis_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>osteoarthritis_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>osteoporosis_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>scoliosis_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>broken bones_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>spinal problems_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>disk problems_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>lupus_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>TMJ, jaw pain_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>spasms, cramps_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>sprains, strains_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>tendonitis, bursitis_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>stiff/painful joints_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>weak/sore muscles_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>neck/shoulder/arm pain_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>low back/hip/leg pain_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>other_____</td></tr> </tbody> </table> | Current | Past | Medication | <input type="checkbox"/> | <input type="checkbox"/> | rheumatoid arthritis_____ | <input type="checkbox"/> | <input type="checkbox"/> | osteoarthritis_____ | <input type="checkbox"/> | <input type="checkbox"/> | osteoporosis_____ | <input type="checkbox"/> | <input type="checkbox"/> | scoliosis_____ | <input type="checkbox"/> | <input type="checkbox"/> | broken bones_____ | <input type="checkbox"/> | <input type="checkbox"/> | spinal problems_____ | <input type="checkbox"/> | <input type="checkbox"/> | disk problems_____ | <input type="checkbox"/> | <input type="checkbox"/> | lupus_____ | <input type="checkbox"/> | <input type="checkbox"/> | TMJ, jaw pain_____ | <input type="checkbox"/> | <input type="checkbox"/> | spasms, cramps_____ | <input type="checkbox"/> | <input type="checkbox"/> | sprains, strains_____ | <input type="checkbox"/> | <input type="checkbox"/> | tendonitis, bursitis_____ | <input type="checkbox"/> | <input type="checkbox"/> | stiff/painful joints_____ | <input type="checkbox"/> | <input type="checkbox"/> | weak/sore muscles_____ | <input type="checkbox"/> | <input type="checkbox"/> | neck/shoulder/arm pain_____ | <input type="checkbox"/> | <input type="checkbox"/> | low back/hip/leg pain_____ | <input type="checkbox"/> | <input type="checkbox"/> | other_____ | <p align="center">RESPIRATORY, CARDIOVASCULAR</p> <table border="1" style="width:100%; 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border-collapse: collapse;"> <tbody> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>bowel problems_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>gas, bloating_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>bladder/kidney/prostrate_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>abdominal pain_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>other_____</td></tr> </tbody> </table> | <input type="checkbox"/> | <input type="checkbox"/> | bowel problems_____ | <input type="checkbox"/> | <input type="checkbox"/> | gas, bloating_____ | <input type="checkbox"/> | <input type="checkbox"/> | bladder/kidney/prostrate_____ | <input type="checkbox"/> | <input type="checkbox"/> | abdominal pain_____ | <input type="checkbox"/> | <input type="checkbox"/> | other_____ |
| Current | Past | Medication | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | rheumatoid arthritis_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | osteoarthritis_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Current | Past | Medication | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <input type="checkbox"/> | <input type="checkbox"/> | coffee, soda_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | other_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Contract for Care</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my massage therapist and other members of my health care team, and my experience of those suggestions. I agree to participate in the self-care program we select. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I expect my massage therapist to provide safe and effective treatment.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Consent for Care</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>It is my choice to receive massage therapy. I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health. I have read and understand this form in entirety. I understand that all therapists located at Synergy Massage & Wellness Center are independent contractors and not employees of SMWC and I agree to release SMWC of any and all liability for any injuries, claims, or damages arising out of any services which I receive from independent contractors at Synergy Massage & Wellness Center.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Signature:_____ Date:_____ Email:_____</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |