Patient Information

Diane Swift, LMP
Hand to Health Massage Therapy
509-660-0585

Name_____DOB_____Age____Male____Female____

Mailing Address_____City_____State_____Zip_____

Home Phone _____Cell_____

Work _____Ext_____ (Is it ok to contact you at this number?) Yes ____No____

Emergency Contact_____Phone_____

Referred by_____

If not referred, how did you hear of this office?_____

Have you received a massage before?_____

What results do you want from your massage session today?_____

Do you exercise?_____ If yes, what type?_____

Medical History

List any medications you are currently taking (including Ibuprofen, Acetaminophen, etc.)_____

Please list any surgeries or injuries in the last 5 years:_____

Are you pregnant?_____

Are you allergic to any oils, lotions or fragrances?_____

Do you or have you had any of the following conditions:

___Skin Disorder	___Whip Lash	___Deep Vein Thrombosis	___Fever/Flu
___Fibromyalgia	___Spinal Cord Injury	___Aneurysm	___Digestive Problems
___Broken Bones	___Stroke	___High/Low Blood Pressure	___Diabetes
___Osteoporosis	___Headaches	___Heart Attack/Disease	___Hypoglycemia
___Joint Dislocation	___Seizure Disorder	___Circulatory Problems	___Kidney Disorder
___Osteoarthritis	___Sleep Disorder	___HIV/AIDS	___Cancer
___Rheumatoid Arthritis	___Anemia/Hemophilia	___Allergies	___Herpes

If you checked any of the above conditions please explain including approximate dates:_____

_____

Please list any skin conditions that may affect your massage including sunburns, rashes, radiation sites, etc._____

Please continue on the other side.....

Because a massage practitioner must be aware of any existing physical conditions that I have, I have listed all my known medical conditions and physical limitations. I understand that it is my responsibility to inform my massage practitioner in writing of any changes in my physical health.

I understand that a massage practitioner is not trained or qualified to diagnose any illness, disease or syndrome. I understand that it is my responsibility to consult a qualified physician for any concerns I may have for my physical, emotional or mental health.

I hereby give permission to Diane Swift, LMP to share my medical information with anyone involved with my treatment.

I also consent to treatment by Diane Swift, LMP in a manner appropriate to my condition and consistent with the scope of practice of massage therapy.

Patient Signature_____Date_____