

The Busy Body

Specializing in stress relief & relaxation for the busy body



Name: _____ Phone # _____

Address: _____

City/State/Zip _____

Email _____

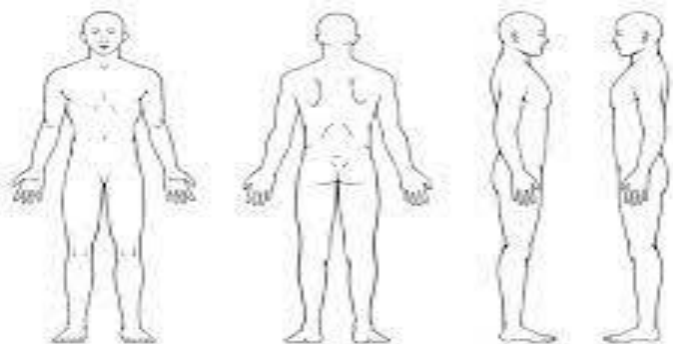
Occupation _____ D.O.B. _____

Emergency Contact _____ Phone # _____

How did you hear about us? _____

Today's Date _____

1. Have you had a professional massage before? Yes No
2. Do you have any difficulty lying on your front, back or side? Yes No
3. Do you have any allergies to oils, lotions, or ointments? Yes No
4. Do you have sensitive skin? Yes No
5. Do you sit for long hours at a workstation, computer, or driving? Yes No
6. Do you perform repetitive movements in your work, sports, or hobby? Yes No
7. Do you experience stress in your work, family, or other aspects of your life? Yes No
8. Is there a particular area where you are experiencing tension, stiffness, pain, or other discomfort? Yes No
9. Do you have goals for this massage session? Yes No



Circle any specific areas you would like your massage therapist to focus on.

Medical History

- | | | |
|---------------------------------------------------------------------------|-----|----|
| 1. Are you currently under medical supervision? | Yes | No |
| 2. Do you see a Chiropractor? How Often? _____ | Yes | No |
| 3. Are you currently taking any medication?
If yes, please list: _____ | Yes | No |

Please check any condition listed below that applies to you:

- | | |
|-----------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis |
| <input type="checkbox"/> Recent accident or injury | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Recent surgeries | <input type="checkbox"/> Headaches/migraines |
| <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Sprains or strains | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Back/neck pain |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> atherosclerosis | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Carpal tunnel syndrome |
| <input type="checkbox"/> Degenerative disc disease | <input type="checkbox"/> Tennis elbow |
| <input type="checkbox"/> Herniated/bulging discs | <input type="checkbox"/> Pregnancy: How many months? _____ |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Deep vein thrombosis/blood clots | <input type="checkbox"/> Crohn's disease |
| | <input type="checkbox"/> Celiac disease |

If there is anything else about your health that you think would be useful for your massage therapist to know please write it here: _____

I, _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that the massage should not be constructed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical alignment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustment, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be constructed as such. Massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of Client _____ Date _____

Signature of massage therapist _____ Date _____