

Patti Crimens
Licensed Massage Therapist

Health and Massage History

Name _____

Address _____

City _____ State _____ Zip _____

Email address _____

Home phone _____ Cell phone _____

Work phone _____ Birthdate _____

Occupation _____ Referred by _____

Have you ever received a professional massage? _____ (yes or no)

If yes, how often? _____ Date of last massage? _____

What results do you want from your massage sessions? _____
(relaxation, for example)

Please check areas of your body that you give permission to receive massage:

___back ___legs ___buttocks ___arms ___neck ___head ___face ___feet

Previous History: (include year and treatment received)

Surgeries:

Accidents:

List current medications, including aspirin, ibuprofen,
etc. _____

List stress reduction and exercise activities, including frequency:

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List areas of TENSION, PAIN, or DISCOMFORT: _____

Check any of the following that apply:

- | | |
|--|--|
| <input type="checkbox"/> bone or joint disease | <input type="checkbox"/> rashes |
| <input type="checkbox"/> tendonitis | <input type="checkbox"/> athletes foot |
| <input type="checkbox"/> bursitis | <input type="checkbox"/> warts |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> constipation |
| <input type="checkbox"/> sprains/strains | <input type="checkbox"/> diverticulitis |
| <input type="checkbox"/> low back, hip, leg pain | <input type="checkbox"/> irritable bowel syndrome |
| <input type="checkbox"/> neck, shoulder, arm pain | <input type="checkbox"/> herpes/shingles |
| <input type="checkbox"/> headaches/head injuries | <input type="checkbox"/> numbness/tingling |
| <input type="checkbox"/> spasms/cramps | <input type="checkbox"/> chronic pain |
| <input type="checkbox"/> jaw pain/TMJ | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> heart condition | <input type="checkbox"/> sleep disorders |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> pregnant? ___stage |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> PMS |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> cancer/tumors |
| <input type="checkbox"/> low blood pressure | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> lymph edema | <input type="checkbox"/> eating disorders |
| <input type="checkbox"/> breathing difficulty | <input type="checkbox"/> depression |
| <input type="checkbox"/> sinus problems | <input type="checkbox"/> drug/alcohol addiction |
| <input type="checkbox"/> allergies | <input type="checkbox"/> nicotine/caffeine addiction |
| <input type="checkbox"/> any contagious diseases | |
| <input type="checkbox"/> any other pertinent information | |

I is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my mind and body. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner, Patti Crimens, any time I feel my well-being is being compromised.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update Patti Crimens, LMT with any changes in my health status.

I acknowledge Patti Crimens has a 24 hour notice on cancellations or payment will be requested.

Signature _____ **Date** _____