ONE SOLID CORE

PATIENT INFORMATION

Please Print Clearly Today's Date: ______________

Name: ______________

Gender: ❑Male ❑Female Birthdate: ______________

Address: ______________

City: ______________ State: ______ Zip: ______

Email: ______________

Referred By: ______________

❑Home ❑Cell ❑ Work Phone: ______________

❑Home ❑Cell ❑ Work Phone: ______________

Occupation: ______________

Employer: ______________

If medically necessary do I have your permission to consult with your primary care physician,? ❑Yes ❑No

Primary Care Physician: ______________

Primary Care Physician Phone Number: ______________

Emergency Contact: ______________

Emergency Contact Phone Number: ______________

MASSAGE HISTORY/TREATMENT INFORMATION

Have you received a professional massage before? ❑Yes ❑No

If yes, frequency ______________ Date of last massage ______________

What results do you want from your massage session? ______________

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

❑Head ❑Face ❑Neck ❑Arms / Hands ❑Chest/Pecs

❑Abdomen ❑Back ❑Glutes / Hips ❑Legs / Feet

Please list in order of importance your areas of concern and symptoms.

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Are you currently working with and receiving treatment from a medical doctor or practitioner? If yes, please explain. ❑Yes ❑No

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Are you currently seeing a psychotherapist or are you attending regular support group meetings? If yes, please explain. ❑Yes ❑No

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List stress reduction and exercise activities. Include frequency.

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List prescribed medications and over the counter drugs, dietary supplements (including vitamins and herbal supplements, etc) that you are currently taking.

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HEALTH HISTORY

Please include date and treatment received for surgeries or accidents:

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Do you currently have any infectious diseases (i.e. cold, flu, HIV, hepatitis, etc) and if yes, please explain. ❑Yes ❑No

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Please check all current and previous conditions and explain

General

current	past	
❑	❑	headaches
❑	❑	sleep disorders
❑	❑	fatigue
❑	❑	infections
❑	❑	fever
❑	❑	sinus
❑	❑	depression

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Reproductive System

current	past	
❑	❑	pregnancy
❑	❑	pms
❑	❑	fibrotic cysts
❑	❑	other________________

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Allergies

current	past	
❑	❑	scents, oils or lotions
❑	❑	detergents
❑	❑	nuts
❑	❑	other________________

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Digestive / Elimination System

current	past	
❑	❑	irritable bowel syndrome
❑	❑	diverticulitus
❑	❑	constipation
❑	❑	diarrhea
❑	❑	gas, bloating
❑	❑	bladder / kidney / prostate
❑	❑	abdominal pain
❑	❑	other________________

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Nervous System

current	past	
❑	❑	head injuries, concussions
❑	❑	dizziness, ringing in the ears
❑	❑	loss of memory, confusion
❑	❑	numbness, tingling
❑	❑	sciatica, shooting pain
❑	❑	chronic pain
❑	❑	depression
❑	❑	herpes / shingles
❑	❑	other________________

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Respiratory & Cardiovascular

current	past	
❑	❑	heart disease
❑	❑	blood clots
❑	❑	stroke
❑	❑	lymphedema
❑	❑	high / low blood pressure
❑	❑	irregular heart beat
❑	❑	poor circulation
❑	❑	swollen ankles
❑	❑	varicose veins
❑	❑	chest pain, shortness of breath
❑	❑	asthma
❑	❑	other________________

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Cancer / Tumors

current	past	
❑	❑	benign
❑	❑	malignant

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Endocrine System

current	past	
❑	❑	thyroid
❑	❑	diabetes
❑	❑	other________________

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Muscles and Joints

current	past	
❑	❑	rheumatoid arthritis
❑	❑	osteoarthritis
❑	❑	osteoporosis
❑	❑	scoliosis
❑	❑	broken bones
❑	❑	spinal problems
❑	❑	disk problems
❑	❑	lupus
❑	❑	TMJ, jaw pain
❑	❑	spasms, cramps
❑	❑	sprains, strains
❑	❑	tendonitis, bursitis
❑	❑	stiff or painful joints
❑	❑	weak or sore muscles
❑	❑	neck, shoulder, arm pain
❑	❑	low back, hip, leg pain
❑	❑	other________________

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Skin Conditions

current	past	
❑	❑	rashes
❑	❑	athlete's foot
❑	❑	warts
❑	❑	acne
❑	❑	other________________

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CONSENT FOR CARE

It is my choice to receive manual therapy and I give my consent to receive treatment. I understand that the massage I receive is provided for the purpose of stress reduction and the relief from muscular tension, spasm, or pain and to increase circulation/energy flow. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and or strokes may be adjusted to my level of comfort. 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 reported all health conditions that I am aware of and will inform the massage practitioner of any changes in my future health status. **Note**: Clients under the age of 18 must be accompanied by a parent or adult legal guardian during the entire session. Informed written consent must be provided by the parent or adult legal guardian on behalf of the minor.

I agree that there shall be no liability on the therapist's part should I not do so. I have read and understand the Notice of Privacy Practices for Protected Health Information, which is posted on the wall of the client waiting area, and I agree to these policies and procedures. Please initial __________.

I, __________________________________, give my permission for you to leave any information for me, and to use your name/clinic name, at the phone numbers listed above.

Client/Guardian Signature: ____ Date: ________________