The Main Street Spa | Massage Therapy

111 North Main Street, Stewartville, MN 55976

Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____ City:_____

State:_____ Zip:_____ Email Address:_____

Phone Numbers: Home:_____ Work:_____ Other:_____

□ Male □ Female Marital Status:_____

Emergency Contact: _____ Phone: _____

Referred to this office by: □ Friend/Family Member Name? _____

□ Event or advertisement _____

Have you ever had a professional massage? Yes No If yes, how long ago? _____

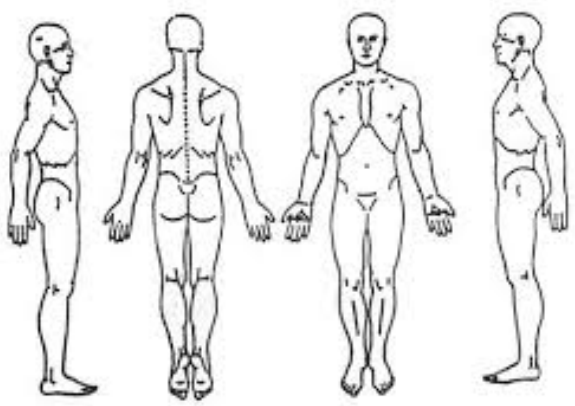
What are your massage therapy goals today? _____

What kind of pressure do you prefer? Light Medium Firm

MEDICAL HISTORY

Please check all conditions that apply and mark areas you would like addressed on the body diagram below:

□ Headaches/migraines
□ Tired/fatigued
□ Fibromyalgia
□ Digestive disturbance
□ Difficulty sleeping
□ High blood pressure
□ Arthritis
□ Multiple sclerosis
□ Ankle/foot pain
□ Anxiety/nervousness
□ Knee pain
□ Low back pain
□ Wrist/hand pain
□ Elbow pain
□ Shoulder pain
□ Right hip pain
□ Left hip pain
□ Ringing in ears
□ Dizziness
□ Failed surgeries
□ Parkinson's disease
□ Numb/tingling in arms/hands
□ Numb/tingling in legs/feet



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PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS: Please Rate Your Symptoms 1-10, 1 being least worrisome

_____ _____

_____ _____

_____ _____

_____ _____

Symptoms are worse in: ▫ Morning ▫ Afternoon ▫ Night
When and how occurred? _____
_____

Symptoms developed from: ▫ Job related injury ▫ Auto accident ▫ Other accident ▫ Illness
▫ Unknown cause ▫ Gradual onset Date occurred: _____

Symptoms have persisted for # ____ Hour(s)____ Day(s) ____ Week(s) ___ Month(s) ____ Year(s)
Symptoms/Complaints: ▫ Come and go ▫ Constant
Have you ever had this before: ▫ No ▫ Yes When? _____

Please check how this affects your life:

▫ Moody
▫ Irritable
▫ Interrupted sleep
▫ Poor attitude
▫ Slower in movement
▫ Restricted daily activity
▫ Unable to work long hours
▫ Lose patience with spouse/ children
▫ Restricted household duties
▫ Exhausted at the end of the day
▫ Hinders ability to exercise or participate in sports
▫ Interferes with hobbies or other activities
▫ Decreased productivity

Are you pregnant? ▫ No ▫ Yes Are you breastfeeding? ▫ No ▫ Yes

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience my pain or discomfort during this session, I will immediately inform the practitioner so the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any other mental or physical ailment of which I am aware. I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness and that nothing said in the course of the session should be construed as such. Because massage should not be performed under certain conditions, I affirm that I have stated all my known medical conditions and answered questions honestly. I agree to keep the practitioner updated as so any changes in my medical profile and understand that there shall be no liability of the practitioners part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of scheduled appointment.

Client signature:_____ Date:_____

Parent/Guardian signature:_____ Date:_____