Please Print: *Information collected is intended to assist in treatment, so please fill out completely.*

Full Name:_____ Marital Status: ○ Single ○ Married ○ Divorced

Address:_____ City_____ Zip_____

Ph# _____ Email: _____ Male ○ Female ○

D.O.B._____ *Last 4 digits SS#*_____ *Newsletter Signup?* ○ *Yes* ○ *No*

Emergency Contact: _____ Relationship_____ Ph#_____

Have you ever had a massage? ☐ Yes ☐ No If yes, when was last session? _____

How did you hear about us?_____

Reason for visit today?_____

Type of session you like to receive: ☐ Therapeutic ☐ Deep Tissue/Sport ☐ Swedish ☐ Inversion Therapy
☐ Cellulite Reduction ☐ Alternative Healing ☐ Unknown

Medical Background:

Medical Doctor: _____ Ph#_____

Are you currently being treated for any medical condition? ☐ Yes ☐ No

If yes, by Whom? _____

Reason for treatment:_____

History of injuries, illnesses and/or surgeries(past 5 Yrs):

_____

_____

_____

Do you still have chronic/ongoing pain for any of the above? ☐ Yes ☐ No/Recovered

Chronic, ongoing pain? ☐ Yes ☐ No *If Yes, Please describe:*

_____

_____

Any activities affect the pain? ☐ Yes ☐ No *If Yes- Please describe:*

_____

_____

History

Activities (*Include work activities, computer, sports, etc.)*

Type/Duration:_____ ○ Daily ○ Weekly ○ Monthly ○ Occasionally

Type/Duration:_____ ○ Daily ○ Weekly ○ Monthly ○ Occasionally

Type/Duration:_____ ○ Daily ○ Weekly ○ Monthly ○ Occasionally

Other:

Chiropractor ○ Yes ○ No *Last Session*_____ *Frequency* ○ Daily ○ Weekly ○ Monthly ○ Occasionally

Have you been sick within the last 24 hours? ○ Yes ○ No *Symptoms*_____

Pain:

Please check all that apply:

☐ Headache	☐ Neck R/L	☐ Chest	☐ Abdomen	☐ Hip R/L	☐ Shoulder R/L
☐ Neck Base	☐ Arm R/L	☐ Pelvis	☐ Groin	☐ Buttocks	☐ Foot R/L
☐ Hand L/R	☐ Calf R/L	☐ Leg R/L	☐ Low Back	☐ Back	☐ Sinus

CONTINUED ON BACK →

Disorders/Disease:

Please check all that apply:

(this information helps your treatment and is not intended for any criminal intent and will not be passed on without your written permission)

Musculosketal	Circulatory	Nervous System	Skin	Medications
☐ Osteoporosis	☐ Varicose Veins	☐ Multiple Sclerosis	☐ Fungal Infection	☐ Blood Thinner
☐ Hypothyroidism	☐ Blood Clots	☐ ALS	☐ Athlete's Foot	☐ Marijuana
☐ Chronic Fatigue	☐ Palpitations	☐ Parkinson's	☐ Impetigo	☐ Street Drugs
☐ Gout	☐ Anemia	☐ Neuritis	☐ Psoriasis	☐ Muscle Relaxers
☐ TMJ	☐ Low Blood	☐ Spinal Cord Injury	☐ Eczema/Dermatitis	☐ Herbal Remedy
☐ Fibromyalgia	☐ High Blood	☐ Seizures/Epilepsy	☐ Easily Irritated	☐ Nicotine
☐ Migraine	☐ PAD/CAD	☐ Bell's Palsy	☐ Allergies* (list below)	☐ Aspirin
☐ Bursitis	☐ Embolism/Thrombus	☐ Dizziness	**OTHER**	☐ OC Pain Meds
☐ Tendonitis	☐ Reynaud's	☐ Trigeminal Neuralgia	☐ Diabetes ☐ PMS	☐ Allergy Meds
☐ Tennis Elbow	☐ Hypertension	☐ Other:_____	☐ Cancer ☐ I.U.D.	☐ Other *(Please List)*
☐ Plantar Fasciitis	☐ Hemophilia		☐ Bipolar ☐ Lupus	_____
☐ Whiplash	☐ Stroke	☐ Cerebral Palsy	☐ HIV/AIDS	_____
☐ Strain/Sprains	☐ Atherosclerosis	☐ Epileptic	☐ Pregnant Now	_____
_____	☐ Hodgkin's disease	_____	☐ Hepatitis	_____
_____	☐ Hemangioma	_____	☐ Depression	_____

****Allergies*** _____

Please Initial each line below:

_____ I confirm that the above information is accurate to the best of my knowledge. I also understand that Therapeutic Body Shoppe does not diagnose disease, prescribe drugs and is not a substitute for medical care.

_____ I understand that this is a professional bodywork session and therapists **will not tolerate sexual actions** or behaviors, and I maybe subject to the termination of the session as well as a ***fees up to 3x the session price***.

_____ I understand that ***missed appointments will be charged the full session price***. I also understand that there is a 24hr cancellation policy/re-schedule policy, in event of less than 24hr I may be charged half price for the session.

_____ I understand that Therapeutic Body Shoppe has the right to refuse me service, if deemed necessary for the protection of all parties.

I, _____, confirm that I have read and understand the above statements. I also state that all above information is accurate and I will alert Therapeutic Body Shoppe in the event that any physical/emotional changes as they occur.

Printed Name:_____ Date:_____

Signature:_____

Under 18 (Parental Signature Required for Consent)

Printed Name:_____ Date:_____

Signature:_____ Relationship_____

Therapist Signature:_____ INT_____