Peak Performace Sports Therapy

Name: ______________________________ Date: ________________
Address: ______________________________ Home Phone: ____________
City: ____________ State: _____ Zip: ________ Cell Phone: ____________
Occupation: ______________________________ Work Phone: ____________
Date of Birth: ______________________________ Email: ________________
Referred by: ______________________________
Emergency Contact: ______________________________ E.C. Phone: ____________

Health / Medical History

Are you experiencing any of the following:

___ Cold/Flu
___ Fever
___ Infections
___ Contagious Conditions
___ Burns/Sunburn
___ Skin Condtions (e.g. warts)
___ Cuts/Bruises
___ Numbness/Tingling
___ Piercing or Stabbing Pain
___ Frequent Headaches
___ Back Pain
___ Arthritis
___ Joint Swelling
___Tendonitis
___ Depression/Anxiety
___ Muscular/Skeletal Disorders
___ New tattoos/piercings
___ Digestive Disorders
___ Possible or Definite Pregnancy
___ Other ______________

Have you ever been diagnosed with, or been advised to seek treatment for any of the following:

___ High / Low Blood Pressure
___ Stroke / TIAs
___ Diabetes / Low Blood Sugar
___ Heart Disease
___ Aneurysm
___ Anemias / Blood Disorders
___ Blood Clots / Phlebitis
___ Other Circulatory Conditions
___ Varicose veins
___ Bruising easily
___ Lymphatic Conditions
___ Kidney / Bladder Conditions
___ Liver / Gall Bladder Conditions
___ Cancer
___ Reproductive System Conditions
___ Allergies
___ Osteoporosis
___ Disc Disorders
___ Neuritis / Nerve Disorders
___ Seizure Disorders / Epilepsy
___ Asthma
___ Chronic Respiratory Conditions
___ Chronic Sinus Conditions

Are you currently:

Taking any prescribed medications? Yes No ______________________________
____

Taking any over the counter medicines, supplements, herbs, etc.? Yes No ______________________________
____

Using any prosthetics? (including contacts & dentures) Yes No ______________________________

Have you ever had any:

Hospitalizations/Surgeries Yes No ______________________________
____

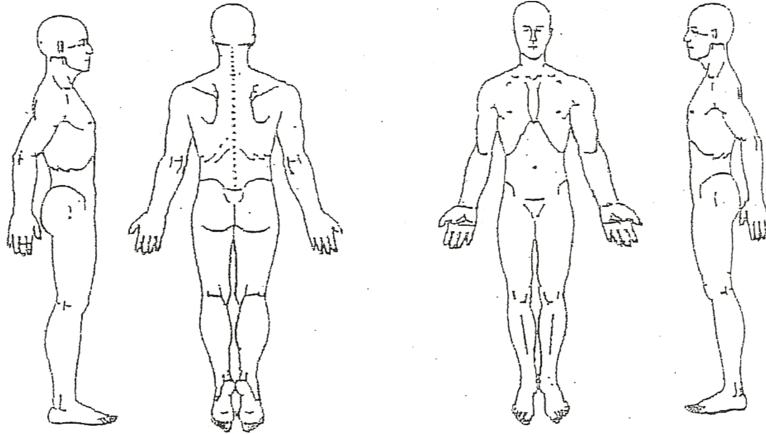
Accidents/Injuries Yes No ______________________________
____

Broken/Dislocated Bones Yes No ______________________________
____

Have you ever experienced professional massage or bodywork? Yes No How recently? ____________________

Massage Therapist Use Only:
____
____
____
____
____

Please describe how you are feeling today, and note any places of tension, pain, discomfort, etc. on the diagram below:



Comments:

____

____

____

Waiver and Release

I, ____, understand that massage is provided for the basic purpose of relaxation, stress reduction and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

Massage services are not meant to take the place of a physician's care. Information exchanged during a massage is educational in nature, not diagnostic or prescriptive, and is to be used at my own discretion. Because massage should not be performed relative to certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I understand that it is my responsibility to keep the massage therapist updated as to any changes in my medical profile.

I hereby waive and release my massage therapist, Peak Performance Sports Therapy and anyone affiliated with it, from any and all liability, past, present and future, relating to massage therapy and body work.

Signature: ____ Date: _______________________________

If client is a minor (under 18 years of age):

By my signature below, I hereby authorize Peak Performance Sports Therapy to administer massage/bodywork therapy techniques to my child or dependent, ____, as they deem necessary.

Signature of Parent or Guardian ____ Date ___________________