

Gold Naprapathic & Wellness Center, P.C.

Name: _____ Date: _____

Address: _____ City _____ Zip _____

(Home)Phone: _____ (Cell)Phone _____

Email: _____ (Work)Phone _____

Occupation: _____

Gender: _____ Date of Birth: _____

In case of emergency, please notify: _____

Telephone: _____ Relationship: _____

Have you had a massage before? _____ What type? _____

Are you under the care of a healthcare professional? _____

Name: _____ Phone: _____

For what condition(s)? _____

Are you taking any medications? (please list) _____

Do you have any of the following:

Skin rash If so, where? _____

Anything contagious

Cold/flu

Injuries/bruises

Open cuts If so, where? _____

Warts If so, where? _____

Severe pain

Please check any that apply:

Arthritis

Depression, Panic disorder, Other psych condition

Diabetes

Diverticulitis

Blood clots

Headaches

Broken/dislocated bones

Heart conditions

Bruise easily

Back problems

Cancer

High blood pressure

Chronic pain

Low blood pressure

Constipation/diarrhea

Insomnia

Auto-immune conditions*

Muscle strain/sprain

Hepatitis (A, B, C, other)

Pregnancy

Skin conditions

Scoliosis

Stroke

Seizures

Surgery

Whiplash

TMJ disorder

Chemical dependency (alcohol, drugs, etc.)

(*AIDS, Fibromyalgia, Chronic fatigue, Lupus, etc.)

Other

Please specify: _____

Do you smoke? _____ Suffer any respiratory conditions? _____

Is there a chance you could be pregnant? _____ How many weeks? _____

How often do you exercise? What activities? _____

Daily water intake: _____ glasses or _____ oz.

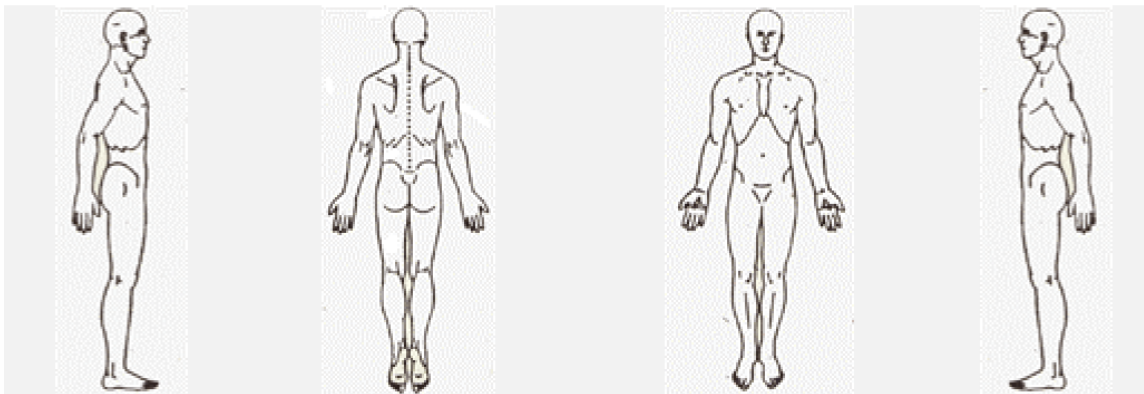
Have you ever had any surgeries or injuries? (please list and date – including any motor vehicle accidents)

Please circle if you are wearing any of the following:

__ contact lenses __ prosthetics __ orthodontics __ dentures __ wig __ hearing aid

Primary reason for seeking massage: _____

Please circle all areas of complaint/concern:



Level of pain: (please circle)

1 2 3 4 5 6 7 8 9 10
least ----- most

When did the pain begin? _____

Is the pain constant, intermittent, associated with any specific activities? (please describe) _____

_____ Areas to

be omitted from massage: _____

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs. Feel free to:

- ◆ move or change position
- ◆ sigh, yawn, change breathing
- ◆ allow stomach gurgling
- ◆ experience and express emotion
- ◆ movement of intestinal gas
- ◆ energy shifts
- ◆ fall asleep
- ◆ interact with memories

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session, and I will be liable for payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature: _____ Date: _____