STREAM POINT Massage

Stream Point Massage
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MEDICAL CONSENT FORM

Name_____ Birth Date _____/_____ / _____

Address _____ Male _____ Female _____

City_____ State_____ Zip _____ Emergency Contact _____

Phone _____ His/Her Phone _____

E-mail _____ Physician_____

How did you hear about us?_____ Pregnant? Y/N If yes, How many weeks? _____

Have you had a massage before?_____ If yes, how frequently? _____

Please list medications you are currently taking. _____

Please List and existing Injuries/Accidents._____

Please List any surgeries and hospitalizations. _____

Your current complaint/condition. _____

When did this condition appear? _____

What activity were you doing when you first noticed it? _____

Has your conditioned worsened or spread to any other areas of your body?_____

What activities can you no longer participate in because they cause pain/weakness? _____

_____

Does the pain lessen/intensify while standing, sitting, sleeping or walking? _____

Have you visited other health care professionals for treatment of this condition? If so, who and when? What types of evaluations and treatments were performed? (MRI, CT scan, X-ray, surgery, physical therapy, spinal adjustments, etc.)?

_____

_____

Are you currently participating in an exercise program? Sports? _____

Describe your program/sport, frequency and duration. _____

What do you hope to achieve from todays session? _____

Check Frequent Body positions or Movements:

_____Standing _____Stooping _____Kneeling _____Driving _____Sitting _____Bending _____Lifting _____ Travel

Problems you've observed. ✓CHECK if occasional ○ CIRCLE if frequent of severe:

HEAD & NECK
_____Headaches
_____Neck pain/tightness
_____Lumps or swelling
_____Migraines
Other_____

EYES
_____Wear Glasses
_____Wear contacts
_____Lasik _____ Date

MUSCULOSKELETAL
_____Aching Muscles
_____Fibromyalgia
_____Aching Joints
_____Arthritis
_____Low back pain
_____Sciatica
_____Shoulder pain R/ L
_____Thoracic Outlet Syndrome
_____Spinal Curvature
_____Painful feet
_____Painful Wrists
_____Carpal Tunnel
_____TMJ
_____Broken Bones (Which)
_____Sprain/Dislocation
Other_____

DIGESTIVE
_____Bloated stomach
_____Constipation
_____Loose bowels
_____Ulcer/colitis
_____Other (Ex: Diverticulosis, IBS)

REPRODUCTIVE/URINARY
_____Currently Pregnant
Weeks _____
Fertility Pregnancy _____
High Risk/
Complicated Pregnancy_____
_____Menstrual Cramps
_____Lump or pain in breast
_____Kidney/bladder
_____Prostate
_____Painful urination
_____Night urinary frequency
_____Menopause
_____Trying to get Pregnant
Other_____

RESPIRATORY
_____Asthma / Bronchitis
_____Easily out of breath
_____Smoker
_____Diabetes
Other_____

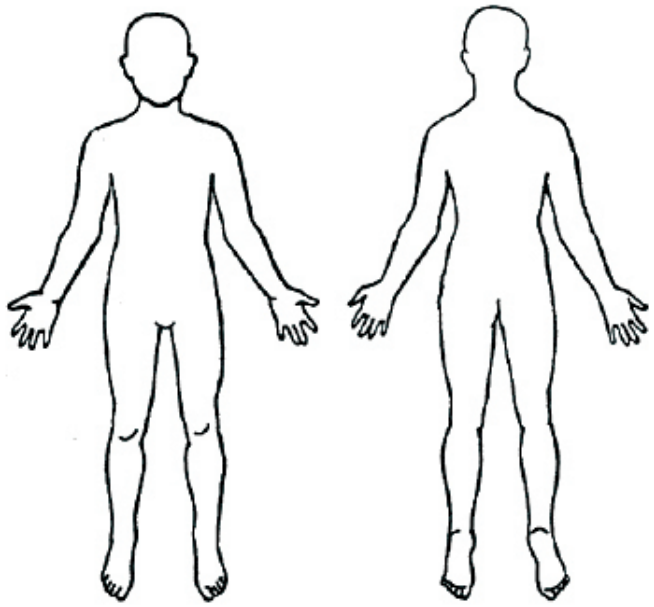
CARDIOVASCULAR
_____High blood pressure
_____Low blood pressure
_____Swelling in feet
_____Leg cramps
_____Heart Disease (type)
_____Stroke / CVA
_____Stent / Shunt
Other_____

SKIN
_____Bruise Easily
_____Varicose Veins
_____Open sores or cuts
_____Skin Allergies
_____Tender areas

NERVOUS SYSTEM
_____Difficulty in relaxing
_____Difficulty in sleeping
_____Tuberculosis
_____Epilepsy
Other_____

BLOOD
_____HIV
_____Anemia
Other_____

OTHER
_____Tumor/Cancer (where)
_____Implants



Please identify current problem areas in your body by circling or shading in the appropriate areas on the diagrams.

I understand massage/bodywork is not a substitute for medical care and any information that is provided to me by the therapist is not diagnostic but for educational purposes only. I will, as much as possible, participate in my own healing. I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Signature _____ Date _____