

## Personal Information

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Numbers: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Days: \_\_\_\_\_

Email Address: \_\_\_\_\_ Eves: \_\_\_\_\_

Employer / Occupation: \_\_\_\_\_

Hobbies/Physical Activities: \_\_\_\_\_

How did you find out about the clinic? \_\_\_\_\_

Primary Health Care Provider: \_\_\_\_\_ Person to Contact in Case of an Emergency: \_\_\_\_\_

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

## Massage History Information

Have you received a professional massage before?  Y /  N

If Yes, What Type: \_\_\_\_\_ How Often: \_\_\_\_\_ Date of Last Massage: \_\_\_\_\_

Depth of massage pressure preferred:  Light  Moderate  Firm  Deep

What are your expectations from this massage session? \_\_\_\_\_

Please feel free, at any time, to communicate to the massage therapist any information about the comfort or discomfort of the pressure or technique being used. It is the intent of the DeAnza College Massage Clinic to provide a therapeutic massage in an academic group setting; however, either party may terminate the massage at any time, for any reason.

## Medical History

**Do you have or have you ever had any of the following:**

| Current                  | Previous                 | Condition                  | Current                  | Previous                 | Condition                           |
|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Acute Infectious Disease   | <input type="checkbox"/> | <input type="checkbox"/> | Hernia                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies: _____           | <input type="checkbox"/> | <input type="checkbox"/> | Insomnia                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis - Osteoarthritis | <input type="checkbox"/> | <input type="checkbox"/> | Irritability / Nervousness / Stress |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis - Rheumatoid     | <input type="checkbox"/> | <input type="checkbox"/> | Muscle cramps / spasms              |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma / Respiratory       | <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Back pain                  | <input type="checkbox"/> | <input type="checkbox"/> | Numbness / Tingling                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Clots / phlebitis    | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Bruise easily              | <input type="checkbox"/> | <input type="checkbox"/> | Poor circulation                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer                     | <input type="checkbox"/> | <input type="checkbox"/> | Poor posture                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold/Flu                   | <input type="checkbox"/> | <input type="checkbox"/> | Skin problems                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain                 | <input type="checkbox"/> | <input type="checkbox"/> | Stroke                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                   | <input type="checkbox"/> | <input type="checkbox"/> | Swollen ankles                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Disc problems              | <input type="checkbox"/> | <input type="checkbox"/> | Swollen joints _____                |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness                  | <input type="checkbox"/> | <input type="checkbox"/> | Tendonitis                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Earache / ringing in ears  | <input type="checkbox"/> | <input type="checkbox"/> | Tremors                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache                   | <input type="checkbox"/> | <input type="checkbox"/> | Varicose Veins                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Foot problems              | <input type="checkbox"/> | <input type="checkbox"/> | Other _____                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease              |                          |                          |                                     |

Are you pregnant?  Y /  N

Are you currently under the care of a health practitioner?  Y /  N

If yes, please explain: \_\_\_\_\_

Please list current prescription and over the counter medications and their associated condition:  
\_\_\_\_\_

Any heart condition? \_\_\_\_\_ Blood Pressure:  Low  Normal  High

Have you been hospitalized or had surgery within the past 2 years?  Y /  N

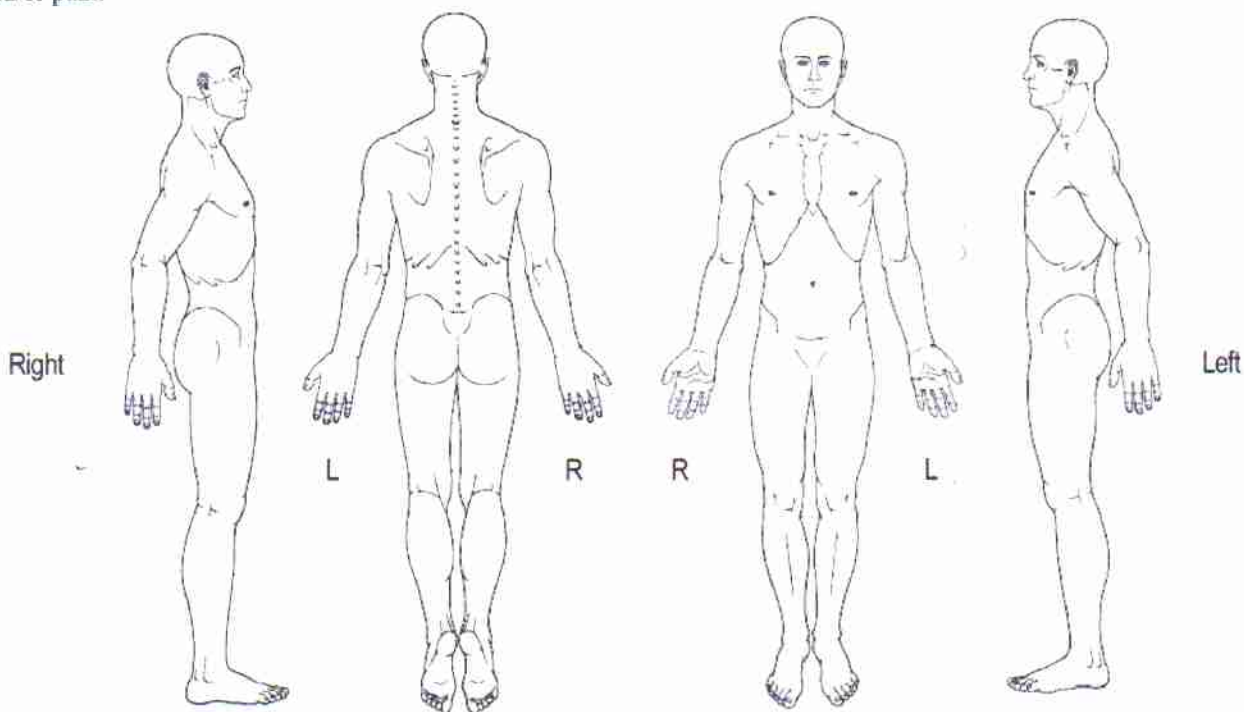
If yes, please explain: \_\_\_\_\_

Have you had any recent injury, serious illness, or are you suffering from a chronic condition?  Y /  N

If yes, please explain: \_\_\_\_\_

Do we need to be aware of any of the following:  hard contact lenses  hearing aid  pace maker

Please indicate with an X on the diagrams the area(s) where you are experiencing muscle and/or bodily discomfort and/or pain:



Which areas require extra focus? \_\_\_\_\_

Which areas would you like avoided? \_\_\_\_\_

The undersigned stipulates the following:

- I understand that the intent of this program is to help students further their education and abilities in the art and science of massage therapy.
- I am solely responsible for my physical condition and for seeking medical treatment when necessary.
- I acknowledge that the intent of the massage is not to diagnose or treat illnesses.
- I further authorize the College to contact my primary health care provider for information pertaining to my health and safety regarding massage.
- I have read, or had read to me, the above information and to the best of my knowledge certify it to be true.
- I have received, read, and understood the *Massage Clinic Agreement* and agree to abide by its terms and conditions.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_