

Center for Integrative BodyWork™

Name: _____ Date: ____/____/____
Address: _____ City: _____ State: ____ Zip: _____
Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____
DOB: ____/____/____ Sex: M F Do you prefer to receive calls at: Home Work Cell Any
Occupation: _____ Employer: _____
Spouse / Significant Other: _____ DOB: ____/____/____
Physician: _____ Date of Last Visit: ____/____/____
In case of emergency call (relationship): _____ Phone: (____) _____
Have you ever experienced a professional massage before? Y N If so, how frequently? _____
Whom may we thank for referring you to us? _____

Please check all of the following that apply, and provide details where necessary :

____ Stress: Daily Work-related Major occurrences only
____ Frequent headaches: Migraines Cluster headaches Tension-headaches Sinus-related
____ Pregnant: Trimester _____
____ High blood pressure. Medication: _____
____ Low blood pressure
____ Epilepsy / Seizure Disorder. Medication: _____
____ Osteoporosis: Early stages Type I Type II
____ Fibromyalgia
____ Allergies: _____
____ Arthritis. Type: _____
____ Diabetes. Type: _____
____ Any communicable diseases (ex. athlete's foot, warts, cold, flu, Hepatitis, HIV, etc) _____
____ Do you have any open cuts, lesions, or sores?
____ Accidents or surgeries? What type and when: _____
____ Cardiac / Circulatory Issues: _____
____ Varicose veins
____ Cancer: _____
____ Inflammation: _____
____ Other conditions, issues, or medications not listed above: _____

On the figures to the right, please indicate the following using the symbols provided:

- P - Pain
- N - Numbness
- T - Tightness
- S - Sensitivity (ex. Ticklish, Bruises)

Please specify your preference for pressure:

Light Moderate Deep Trigger Point (focused)

What are your goals for this session? _____

