

A Touch of Health
Melissa K. Merritt, LMT
Confidential Patient Health Record

Today's Date: _____

Personal Information

First: _____ Middle: _____ Last: _____

Sex: Male / Female Birth Date: ____ / ____ / ____ Age: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____ Email Address: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Status: Single Married Divorced Widowed Separated

Business Name: _____ Occupation/Job Title: _____

Referred By: _____

Would you like to receive our newsletters via email? Yes No

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service.

Have you experienced a professional massage or bodywork session? yes No How recently? _____

What level of pressure do you prefer? Light Medium Firm I don't know

Please List all **health conditions/diseases** (Please include date of diagnosis if possible).

Please list all **surgical procedures**.

Please list any significant **falls** and **traumas**.

Please list any current **medications** you are taking.

- Yes No Do you frequently suffer from stress?
- Yes No Do you experience frequent headaches?
- Yes No TMJ pain/ gritting, grinding, or pain in the jaw?
- Yes No Do you have high blood pressure? If yes, are you monitoring the level? _____

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- Yes No Do you have any food/chemical allergies? If yes, what? _____
- Yes No Do you bruise easily?
- Yes No Are you sensitive to touch or pressure in any specific area? Explain. _____
- Yes No Are you/could you be pregnant?
- Yes No Do you experience any sharp shooting pain? If yes, where _____ and have you had it checked by a chiropractor or doctor?

Please list any other details about your health or emotional state you feel the therapist should know:

Current Condition

Unwanted Condition (Why are you here today?): _____

Please Label on the Diagram the Area of Discomfort

→ → → → → → →

When did this Condition BEGIN? ____/____/____

Has it ever occurred before? Yes No. When? _____

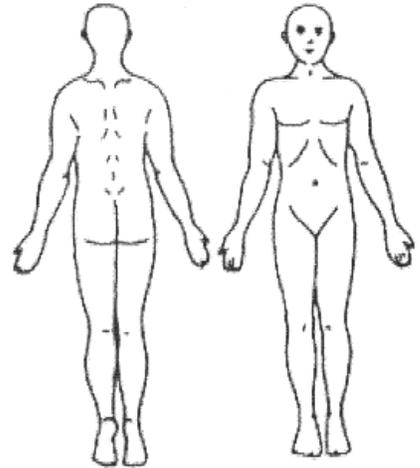
Is the Condition: Auto Related Job Related Home Injury

Slip or Fall Lifting Slept Wrong Unknown Cause Other

Explain: _____

Date of Accident: _____ Time of Accident: _____ am /pm

Condition/Pain STARTED on what Date: _____



I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature _____ Date _____

Client Name _____