Sound Body
MYOTHERAPY & MASSAGE

Patient Information

Name : _____ Birth Date: _____

Gender: _____ Preferred Pronouns: _____

Street Address: _____ City: _____State_____Zip_____

Occupation: _____ Email: _____

Primary Phone: _____ Cell phone (if different) _____

Emergency Contact _____ Relationship: _____ Phone: _____

Medical History

List any conditions being monitored by your health care provider(s):

_____

_____

_____

List (include dates and treatment when possible):

Major Illnesses:_____

Accidents:_____

Surgeries:_____

Current Medications and/or Supplements (you may attach another sheet if you'd like):

_____used for _____

_____used for _____

_____used for _____

_____used for _____

_____used for _____

_____used for _____

_____used for _____

Medical Conditions

Check all that apply and explain when appropriate:

- ☐ Arthritis/painful joints (where?) _____
- ☐ Arm/ hand issues—pain, numbness tingling _____
- ☐ Back issues: herniated discs, scoliosis, pain_____
- ☐ Blood issues: clots, bruise easily, disease _____
- ☐ History of cancer: type/treatment? _____
- ☐ Circulatory issues? _____
- ☐ Depression/Anxiety? _____
- ☐ Diabetes? (insulin/medication?) _____
- ☐ Edema/Swelling/"bogginess" (where) _____
- ☐ Fibromyalgia; ME/CFS (chronic fatigue syndrome) _____
- ☐ Heart Issues: pace maker; bypass surgery; birth defect heart failure _____
- ☐ Head issues: frequent headaches; migraines _____
- ☐ High or Low blood pressure (controlled?) _____
- ☐ Face/Jaw Issues _____
- ☐ Kidney issues/disease/stones? _____
- ☐ Leg, ankle, or foot issues—sciatica; gout; pain _____
- ☐ Lung issues? Breathing issues? Asthma? _____
- ☐ Neck issues: whiplash, disc issues, injuries? _____
- ☐ Shoulder issues: _____
- ☐ Skin issues—rashes, athlete's foot, warts? _____
- ☐ Varicose veins? _____
- ☐ Other: _____

Is there anything else you would like me to know?

Informed Consent for Treatment

- This information is correct, and I have stated all medical information that I am aware of and will update my massage therapist of any changes in my health.
- I take responsibility for alerting my massage therapist of any physical or mental conditions that could affect the outcome of my treatment.
- I understand that massage therapists do not diagnose illness, disease, or any physical or mental issue. I acknowledge that massage is not a substitute for medical examination or diagnosis.
- I understand that massage therapy is non-sexual touch and inappropriate behavior will end the session.
- I understand that cancellations should be made 24 hours in advance whenever possible; however, I understand that if I wake up sick on the day of my appointment I may cancel that day. I understand that there is a $50 fee for “no showing” without any communication prior to my appointment.

_____ _____

Signature (parent or legal guardian if minor) Date