Trigger Point and Neuromuscular Therapies
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Name_____ Primary contact phone #: _____

Address_____ Secondary contact phone #:_____

_____ (Please asterisk which number is best to reach you)

Referred by: _____ Email: _____

Date of Birth_____ Emergency contact::_____

Occupation_____

Hobbies_____

Please indicate if you have a history of any of the following conditions:

_____High blood pressure	_____Osteoporosis	_____Cancer
_____Heart problems	_____Whiplash	_____Broken bones
_____Varicose veins	_____Neck Pain	_____Diabetes
_____Phlebitis	_____Low back pain	_____Skin diseases
_____Hematomas	_____Sinus problems	_____Plantar warts
_____Blood clots	_____TMJ syndrome	_____HIV+
_____Thrombosis	_____Headaches	_____Communicable disease
_____Osteoarthritis	_____Insomnia	_____Gastrointestinal issues
_____Rheumatoid arthritis	_____PMS	_____Breast reduction, implants or removal

Is there a physician treating you now? _____

For what conditions is this doctor treating you? _____

Name of doctor_____

Location/address of doctor_____ Doctor's phone: _____

Are you currently taking any medication? _____
Are you pregnant? _____
Do you have allergies? _____
Do you wear glasses? _____ Contacts? _____
Length of time spent seated and/or in a car per day:_____

Self-perceived stress: (circle) High Medium-High Medium Medium-Low Low

Please list any major falls, accidents, injuries and/or surgeries *including month/year*:

How do you feel in general? (e.g., happy, tired, stressed, unbalanced, etc.)

In what way do you feel massage and/or myofascial trigger point therapy will benefit you?

How do you feel about your health? (circle) poor fair good excellent

Have you recently participated in sports or other rigorous activity?

Areas needing special attention:

Other forms of treatment tried (circle): PT chiropractic massage tens acupuncture other
Did they help?

Any bulging or herniated discs, stenosis, or other significant diagnoses of any kind:

What increases your pain?

What lowers your pain?

Do you, or have you worn shoe orthotics? NO / YES
How long have you been using your current pair?

Exercise: (circle one) Not able at this time # ____x per week What?:

Do you have any children, are you active with childcare, or any care giving? NO YES
If YES, how many, what age(s):

Are you a smoker? NO / YES How many cigarettes per day?____ Alcohol intake? _____drinks/day

How much water do you consume per day?

What vitamins/supplements do you currently take?

Do you regularly floss your teeth?

Food cravings: NO / YES If YES, what?
Food sensitivities: NO / YES If YES, what?

Any other information that is important to your session:

I, undersigned, have thoroughly read and answered all questions truthfully. If I have any doubts or concerns about massage therapy with regards to my health, I have talked about it with the therapist and my doctor. I understand that massage therapy services are designed to be a health aid and are in no way to take the place of doctor's care when indicated. Any information exchanged during any massage visit is educational in nature and neither replaces nor overrides the care or protocol of a qualified medical doctor. I understand that massage therapy is intended to help me relieve minor aches and pains and increase body-mind awareness, and is to be used at my own discretion.

Date _____

Client signature_____