BODYSCAPES Massage Therapy Form

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip code: _____

Home phone: _____ Cell phone: _____

Email: _____Referred by: _____

Date of birth: _____ Age: _____ Occupation: _____

Emergency Contact (name/phone): _____

Have you ever received a professional massage? □ Yes □ No

What are your reasons for receiving massage therapy today? _____

_____

Onset of condition: _____ Cause (if known): _____

Has your condition been diagnosed by a Physician? □ Yes □ No

Would you be interested in receiving acupuncture and/or Chinese herbs? □ Yes □ No □ Maybe

Conditions

Please check or list any condition(s) of which I should be aware:

□ Stress	□ Muscular pain	□ Carpal tunnel	□ Asthma
□ Anxiety	□ Low back pain	□ Athlete's foot	□ Allergies
□ Tension headache	□ Neck pain	□ Digestive problems	□ Sinus trouble
□ Migraine	□ Arthritis	□ Crohn's disease	□ High blood pressure
□ Insomnia	□ Osteoporosis	□ Constipation	□ Cancer
□ Fatigue	□ Tendonitis	□ Diarrhea	□ Diabetes
□ Depression	□ Sciatica	□ IBS	□ Varicose veins
□ PMS	□ Disc problems	□ Weight issues	□ Blood clots
□ Menopause	□ Plantar fasciitis	□ Respiratory	□ Pregnant
□ Muscle spasm	□ TMJ	conditions	□ AIDS/Hepatitis C

□ Other: _____

Do you have any allergies to massage lotions, oils, or essential oils? Yes No

List: _____

Sleep

Do you sleep well? □ All the time □ Most of the time □ Some of the time □ Hardly ever

Do you fall asleep easily? Yes No

Do you feel rested when you wake? Yes No

Do you wake during the night? Yes No

Do you fall back to sleep easily? Yes No

Do you have lots of dreams? Yes No

Do you have sleep apnea? Yes No

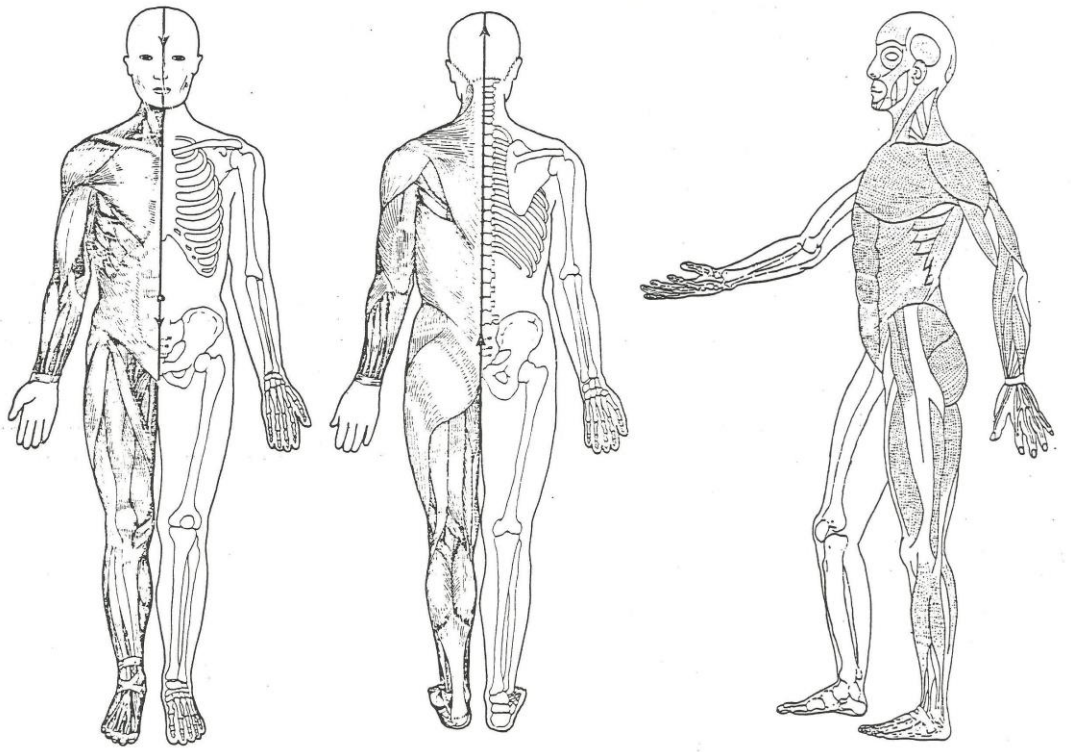
Do you get night sweats? Yes No

Do you nap during the day? Yes No

Average hours of sleep per night: _____ Energy level (10 being best)? 1 2 3 4 5 6 7 8 9 10

Neuromuscular Pain Please circle the areas of pain or discomfort.

Describe your pain:
□ Dull
□ Achy
□ Sharp
□ Cramping
□ Burning
□ Numbness
□ Fixed
□ Refers
□ Stiffness
□ Swelling
□ Moves around
□ Throbbing
□ Constant
□ Comes & goes
□ Worse AM
□ Worse PM
□ Worse in cold weather
□ Worse in hot weather



Pain Scale (10 being the worst): 1 2 3 4 5 6 7 8 9 10

Does heat make it feel better? Yes No Does cold make it feel better? Yes No

Have you used any self-care techniques (cold/heat pack, self massage, biofeedback, etc.)? Yes No

Have you received any physical therapy or other types of therapy for your pain? Yes No

Do you take any prescription drugs or over-the-counter drugs for your pain? Yes No

Specify: _____

Stress How would you rate your overall stress level:

□ **Acute** (occurs for short periods of time causing anger, irritability, anxiety, periods of depression, headache, pain, stomach upset, dizziness, heart palpitations, shortness of breath, hypertension and bowel disorders)

□ **Episodic** (will last longer than acute stress causing periods of intermitted depression, anxiety disorders, emotional distress, ceaseless worrying, and persistent physical symptoms similar to those found in acute stress. Symptoms often associated with Type A personality)

□ **Chronic** (brought on by long-term exposure to stressors that cause more serious and chronic health issues such as chronic fatigue, clinical depression, sleep disorders, high blood pressure, auto-immune disorders, etc)

□ **Mild** (Symptoms are mild and dissipate quickly. No long term effects)

Do you receive weekly counseling/psychotherapy? _____

Do you regularly do any awareness practices (meditation, yoga, tai chi, prayer, affirmations, etc.) Yes No
What are the primary causes of stress in your life? _____

Diet

How would you describe your diet? □ Unhealthy □ Fair □ Good □ Fantastic

How is your appetite? _____ How many meals per day do you eat? _____

How much water do you drink per day? _____Do you drink caffeine? _____ How many cups per day? _____

Are you a vegetarian or vegan? _____List sources of meat/protein: _____

List any food allergies or sensitivities: _____

Do you eat regularly at fast food restaurants? _____ Times per week you eat out? _____

Do you eat a lot of processed food? _____ Do you eat late at night? _____ Do you chew your food well? ____

Do you think you get enough fresh fruits, vegetables, and whole grains daily? _____

Do you drink alcohol? _____How much? _____ Do you smoke cigarettes? _____ How much? _____

Exercise

How often do you exercise? _____

What kind of exercise do you do? _____

Do you like to exercise? _____

Are there any reasons and/or conditions that prevent you from exercising regularly? Yes No

Specify: _____

How would you describe your health in general? _____

_____

_____

Additional comments: _____

_____

_____

Thank you for filling out this form. All information supplied by you is kept confidential.