



Rehoboth Beach Bodywork, LLC

MEDICAL HISTORY INTAKE

DATE: _____

NAME: _____			
Home Address: _____			
City: _____	State: _____	Zip Code: _____	
Telephone: _____	Cell: _____	Work: _____	
Date of Birth: _____	Email: _____		

When was your last professional massage? _____

Occupation/daily activities/exercise: _____

*If you answer **Yes** to any of the following questions, please explain below.*

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Are you wearing contacts?
<input type="checkbox"/>	<input type="checkbox"/>	Are you diabetic?	<input type="checkbox"/>	<input type="checkbox"/>	Are you epileptic?
<input type="checkbox"/>	<input type="checkbox"/>	Do you experience frequent headaches?			
<input type="checkbox"/>	<input type="checkbox"/>	Do you have high blood pressure?			
<input type="checkbox"/>	<input type="checkbox"/>	Have you had any recent surgeries?			
<input type="checkbox"/>	<input type="checkbox"/>	Have you had any broken bones in the last two years?			
<input type="checkbox"/>	<input type="checkbox"/>	Do you have cardiac or circulatory problems?			
<input type="checkbox"/>	<input type="checkbox"/>	Do you have numbness or stabbing pains?			
<input type="checkbox"/>	<input type="checkbox"/>	Do you have varicose veins? <i>If so, where?</i>			_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any skin or nut allergies? <i>Please list:</i>			_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any other medical condition I should be aware of?			_____

Please explain any items marked yes above: _____

Please list any medications you are currently taking. _____

What specific areas would you like me to focus on? _____

Are there any specific areas you would like me to avoid? _____

Client Signature

Date



Rehoboth Beach Bodywork, LLC

Massage Therapy Consent Form

I, _____ understand that massage therapy provided by Rehoboth Beach Bodywork, LLC is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation, and offer a positive touch.

The general benefits of massage, possible massage contraindications and the treatment procedures have been explained to me. **I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my primary caregiver for any condition I may have.** I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the Massage Therapist of all my known physical conditions, mental conditions, medical conditions, and medications. I will keep the Massage Therapist updated on all changes.

I have received a copy of the therapist's policies, and understand them and agree to abide by them.

Client Signature

Date