Gold Naprapathic & Wellness Center, P.C.

Name: _____ Date: _____

Address: _____City_____ Zip_____

(Home)Phone:_____(Cell)Phone_____

Email: _____(Work)Phone_____

Occupation: _____

Gender: _____ Date of Birth: _____

In case of emergency, please notify: _____

Telephone:_____ Relationship: _____

Have you had a massage before? _____ What type? _____

Are you under the care of a healthcare professional? _____

Name: _____ Phone: _____

For what condition(s)? _____

Are you taking any medications? (please list) _____

Do you have any of the following:

__ Skin rash If so, where?_____

__ Cold/flu

__ Open cuts If so, where?_____

__ Severe pain

__ Anything contagious

__ Injuries/bruises

__Warts If so, where?_____

Please check any that apply:

__ Arthritis

__ Diabetes

__ Blood clots

__ Broken/dislocated bones

__ Bruise easily

__ Cancer

__ Chronic pain

__ Constipation/diarrhea

__ Auto-immune conditions*

__ Hepatitis (A, B, C, other)

__ Skin conditions

__ Stroke

__ Surgery

__ TMJ disorder

(*AIDS, Fibromyalgia, Chronic fatigue, Lupus, etc.)

__ Depression, Panic disorder, Other psych condition

__ Diverticulitis

__ Headaches

__ Heart conditions

__ Back problems

__ High blood pressure

__ Low blood pressure

__ Insomnia

__ Muscle strain/sprain

__ Pregnancy

__ Scoliosis

__ Seizures

__ Whiplash

__ Chemical dependency (alcohol, drugs, etc.)

__ Other

Please specify: _____

_____

Do you smoke? _____ Suffer any respiratory conditions? _____

Is there a chance you could be pregnant? _____ How many weeks? _____

How often do you exercise? What activities? _____

Daily water intake: _____ glasses or _____oz.

Have you ever had any surgeries or injuries? (please list and date – including any motor vehicle accidents)

_____

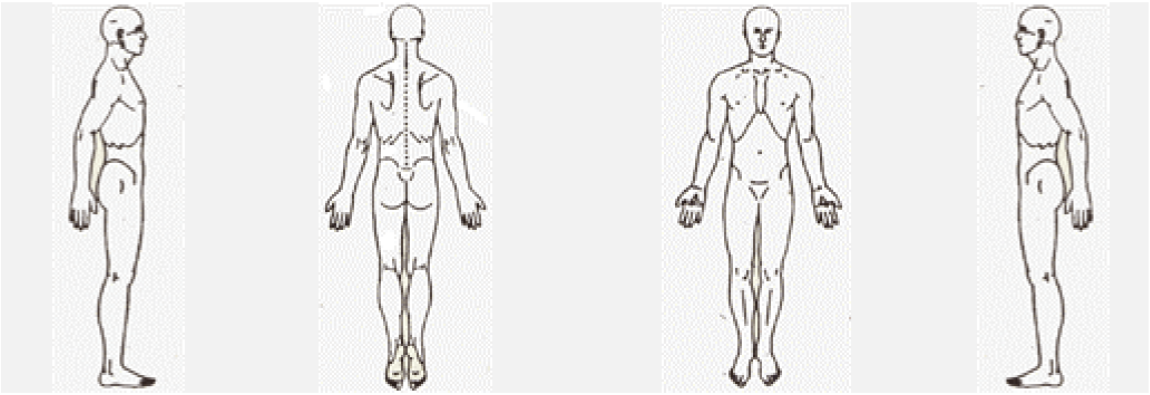
_____

Please circle if you are you wearing any of the following:

__ contact lenses __ prosthetics __ orthodontics __ dentures __ wig __ hearing aid

Primary reason for seeking massage: _____

Please circle all areas of complaint/concern:



Level of pain: (please circle)

1 2 3 4 5 6 7 8 9 10

least ---------- most

When did the pain begin? _____

Is the pain constant, intermittent, associated with any specific activities? (please describe) _____

_____Areas to be omitted from massage: _____

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs. Feel free to:

- move or change position
- sigh, yawn, change breathing
- allow stomach gurgling
- experience and express emotion
- movement of intestinal gas
- energy shifts
- fall asleep
- interact with memories

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session, and I will be liable for payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature: _____ Date: _____