Therapeutic Massage Center, Inc.
666 Dundee Road Suite 1903
Northbrook, IL 60062
312-850-0550

Name:_____Date:_____

Address:_____
(Street) (City) (State) (Zip)

Telephone: (Cell)_____(Home)_____Birthdate:_____Age:_____

Email Address:_____

Occupation:_____Employer:_____Referred By:_____

1. What is the primary reason for today's appointment? What are your expectations?

_____

_____

_____

2. What has been your previous experience with massage therapy, bodywork or other types of therapies?

_____

_____

_____

3. Please circle any of the following items that apply to you, either in the past or currently.

Arthritis	Asthma	Automobile Collision	Buritis
Blood Clots	Bone Fractures	Cancer	Carpal Tunnel Syndrome
Cartilage Tears	Chronic Pain	Colitis	Colostomy
Coronary Bypass	Diabetes	Dizziness/Vertigo	Easy Bruising
Epilepsy	Epstein-Barr	Fibromyalgia	Foot Surgery
Heart Problems	Headaches	Herniated Disc	Herpes
High Cholesterol	HIV/AIDS	Hemophilia	High Blood Pressure
Infectious Conditions	Joint Replacement	Kidney Ailment	Laminectomy
Ligament Tears	Lupus	Major Fall	Migraines
Muscular Dystrophy	MS	Neck/Spine Injury	Oral Surgery
Osteoporosis	Pregnancy	Sciatica	Scoliosis
Spinal Fusion	Tendinitis	TMJ	Tuberculosis
Tumors	Ulcer	Varicose Veins	Whiplash

Other:_____

Please, explain each of the items you circled above providing specific information such as frequency, intensity, dates of surgery, etc: (include medications you are currently taking)

_____

_____

_____

_____

4. In the past year, have you experienced emotional trauma? YES NO

Explain:_____

_____

_____

5. Miscellaneous: (Circle of answer applicable items)

Wear contact lenses Pacemaker Wear dental appliance Hearing aid

Wear orthopedic device in shoe Allergies_____

SPECIAL DIET:_____

Physician:_____Telephone:_____

Do I have permission to contact your physician should the need arise? YES NO

Frequency of exercise: REGULARLY OCCASIONALLY NEVER

Please indicate the sports/exercise in which you participate:_____

The courtesy of a 24 hour cancellation is required in order to cancel or change your appointment or you will be charged in full.

I understand that massage therapy does not diagnose. It has been made clear to me that this massage therapy session is educational in nature and intended to help me become more familiar with and aware of my own health status and make me more comfortable in my body.

Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated as to my physical health.

With this in mind, I agree to have massage therapy treatment(s) and hold the therapist harmless for any problems that might arise as a result of the massage.

Signature_____Date_____

Please circle, or indicate with an X, areas of pain or muscular tension that you are experiencing and would like to address: