Therapeutic Massage Center, Inc.
1332 Waukegan Road
Glenview, IL 60025
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?

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

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

Arthritis	Asthma	Automobile Collision	Bursitis
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	Tendonitis	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)

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

Explain:____

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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: