Optimum Therapies   Massage Intake/Health History

517 E. Clairemont Avenue
Eau Claire, WI 54701
715.855.0408

916 15th Avenue
Menomonie, WI 54751
715.233.6230

250 Buffalo St. Suite B
Mondovi, WI 54755
715.926.3556

Name: ______________________________ Sex: ☐ Female ☐ Male

Address: ______________________________
Street City State Zip

Phone (home): (work): (cell):

E-mail address: ______________________ May we contact you with news and special promotions? : ☐ Yes ☐ No

Marital Status: Occupation Date of Birth:

Stress Level: _____Low _____Medium _____High Reason for appointment? ______________________

How did you hear about Optimum Therapies?

☐ Friend f so, please share:
☐ Optimum Website
☐ Yellow Pages
☐ Gift Certificate
☐ Community Event
☐ Drive By

What type of exercise training do you partake in?

Have you seen a medical doctor within the last six months? : ☐ Yes ☐ No

Primary Medical Physician: Chiropractor:

Which of the following have you ever been diagnosed as having?

☐Cancer
☐Heart Problems
☐High Blood Pressure
☐Asthma
☐Emphysema/Bronchitis
☐Chemical Dependency
☐Thyroid Problems
☐Diabetes
☐Multiple Sclerosis
☐Rheumatoid Arthritis
☐Other Arthritic Conditions
☐Anemia
☐Hepatitis
☐Stroke
☐Other:

Which of the following have you experienced within the past 12 months?

☐Dislocations
☐Fractures
☐Sore Arms
☐Numbness/Tingling
☐Nausea
☐Low Back Pain
☐Neck Injuries
☐Fevers
☐Back Injuries
☐Neck Stiffness
☐Swelling/Redness
☐Chronic Heartburn
☐Mid-Back Pain
☐Headaches
☐Pulled Muscles
☐Recent Surgeries
☐Balance Problems
☐Light Headedness
☐Muscle Cramping
☐Pregnant Due Date:

DISCLOSURE STATEMENT:

Massage therapy is a treatment modality designed for problems associated with the musculoskeletal system such as chronic muscle stiffness, loss of range of motion, chronic musculoskeletal pain, lymphatic retention and diminished bioenergy. Massage therapy is contraindicated under certain medical conditions, because of this, it is absolutely necessary for clients to disclose their medical history to their massage practitioner. Your signature represents your complete medical disclosure and your understanding that massage therapy is not a substitute for a medical examination, diagnosis, or treatment.

Signed: ______________________________ Date: ____________________