



MASSAGE REGISTRATION

Name (print): \_\_\_\_\_ Sex:  Female  Male  
First M Last

Address: \_\_\_\_\_  
Street City State Zip

Phone (home): \_\_\_\_\_ (work): \_\_\_\_\_ (cell): \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Occupation \_\_\_\_\_

Stress Level:  Low  Medium  High Reason for appointment? \_\_\_\_\_

How did you hear about Optimum Therapies?

- |  |  |
|--|--|
| <input type="checkbox"/> Friend If so, please share: _____ | <input type="checkbox"/> Community Event |
| <input type="checkbox"/> Gift Certificate                  | <input type="checkbox"/> Yellow Pages    |
| <input type="checkbox"/> Optimum Website                   | <input type="checkbox"/> 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?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Chemical Dependency  | <input type="checkbox"/> Other Arthritic Conditions |
| <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Thyroid Problems     | <input type="checkbox"/> Anemia                     |
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Hepatitis                  |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Multiple Sclerosis   | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Emphysema/Bronchitis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Other                      |

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

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Dislocations      | <input type="checkbox"/> Fevers            | <input type="checkbox"/> Pulled Muscles            |
| <input type="checkbox"/> Fractures         | <input type="checkbox"/> Back Injuries     | <input type="checkbox"/> Recent Surgeries          |
| <input type="checkbox"/> Sore Arms         | <input type="checkbox"/> Neck Stiffness    | <input type="checkbox"/> Balance Problems          |
| <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Swelling/Redness  | <input type="checkbox"/> Light Headedness          |
| <input type="checkbox"/> Nausea            | <input type="checkbox"/> Chronic Heartburn | <input type="checkbox"/> Muscle Cramping           |
| <input type="checkbox"/> Low Back Pain     | <input type="checkbox"/> Mid-Back Pain     | <input type="checkbox"/> Pregnant: Due Date: _____ |
| <input type="checkbox"/> Neck Injuries     | <input type="checkbox"/> Headaches         |  |

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: \_\_\_\_\_