Professional Therapeutic Massage, LLC

108 Norwich Avenue
Colchester, CT 06415
(860) 537-1915

Date: _____

Name: _____ Gender: _____ Date of Birth: _____

Address: _____City, State, Zip_____

Phone: _____(day) _____(evening) Occupation:_____

Email:_____ We will NEVER sell, rent, or otherwise disclose this information

Have you received massage before? _____ How did you hear about us? _____

Describe any accidents, injuries or surgeries:

More than 5 years ago: **_____**

_____

Less than 5 years ago: **_____**

_____

Are you receiving Chiropractic care? _____ Name of Chiropractor: _____

Are you currently receiving any medical treatment? _____

Are you taking any medications? _____If yes, please list_____

Are you currently experiencing any of the following?

	Pregnancy		**Flu or Cold**		**Contagious Disease**
	Inflammation		**Fever**		**Rash or Skin Condition:**
	Infection		**Injury**		**If so, where? _____**

HABITS:

Alcohol? _____ Tobacco? _____ Caffeine _____

Exercise? _____

Posture assumed most of the day? _____

Sleep Difficulties? Please describe _____

Where do you tend to hold stress in your body? _____

Do you have any especially tender-to-touch areas? _____

Why have you come for a massage? _____

_____

-Over -

Have you ever experienced any of the following? Please place a ✓ if you have ever experienced any of the conditions and an X if you are currently experiencing the condition:

_____Acne
_____Allergies
_____Anemia
_____Anxiety
_____Arrhythmia
_____Arteriosclerosis
_____Arthritis
_____Asthma
_____Back Pain
_____Broken Bones
_____Bursitis
_____Cancer
_____Carpal Tunnel Syndrome
_____Circulation Problems
_____Colitis
_____Constipation
_____Depression
_____Diarrhea
_____Diabetes
_____Digestive Problems
_____Disc Problems
_____Diverticulitis
_____Epilepsy/Seizures
_____Eczema
_____Fibromyalgia
_____Fracture
_____Gout
_____Headaches
_____Heart Attack
_____Hemophilia
_____Herpes
_____High Blood Pressure
_____Insomnia
_____Low Blood Pressure
_____Lymphoma
_____Lymphedema
_____Migraines
_____Muscle Spasms
_____Numbness
_____Phlebitis
_____Psoriasis
_____Rashes
_____Ringworm
_____Schizophrenia
_____Sciatica
_____Stiff Joints
_____Skin Allergies
_____Strains
_____Sprains
_____Excess Stress
_____Stroke
_____Swollen Feet
_____Swollen Legs
_____Swollen Glands
_____Tendonitis
_____Tingling
_____Tumors
_____Varicose Veins
_____Whiplash

For Women Only:
_____Menstrual Cramps
_____Excessive Bleeding
_____No Periods
_____PMS

Name of your Doctor: _____

Please read and sign the following:

I acknowledge that the above information is complete and accurate to the best of my knowledge. I give Professional Therapeutic Massage, LLC & its staff permission to contact my Doctor should the need arise. I understand that massage therapy appointments are my personal financial responsibility and I agree to pay for these services at the time of treatment, unless other arrangements have been made.

_____ _____

Your Signature **Date**

24 hours notice is required if you must cancel an appointment. Cancellations without 24 hours notice will need to be billed at the regular rate.

To Print this form:

1. Put the cursor on the 1st page of the document and select the file/print menu option.

2. Select “current page” and the number of copies and hit print.

3. Take the pages you just printed and put them back into the printer tray **FACE UP**, **Bottom of Form goes in first.**

4. Put your cursor on the 2nd page of the document. Choose “current page” on the print option screen and the number of copies and print.