SunSpace.Life
Massage Therapy

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Patient Information

Name_____ Date_____
Address_____ City_____Zip_____
Personal Phone_____ Work Phone_____
Email_____
Birthdate_____ Date of Injury_____
Occupation_____ Employer_____
Referring Doctor_____Phone_____
Car Accident Claim? Yes___No__ If Yes, Claim Number_____

Check any of the following you have or that you have had:

Bone Joint Disease
Tendonitis
Bursitis
Arthritis/Rheumatism
Broken/Cracked Bones
Sprains
Dislocations
Irregular Sleep Patterns
Numbness Arms or Legs
Anxiety or Nervousness
Depression
Alcohol/Drug Addiction
Muscle Spasms/Cramps
Pregnancy (Due Date_____)

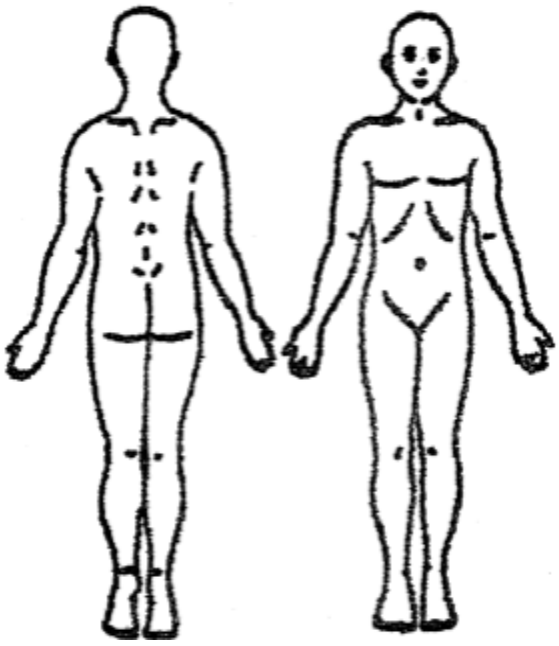
Skin Disorders
Vision Impairment
Hearing Impairment
Jaw Discomfort
Headaches
Sinus Problems
Concussion/Head Injury
Digestive Problems
Colitis/Bowel Disease
Eating Disorders
Significant Weight Change
Diabetes
High Blood Pressure
Low Blood Pressure

Heart Disease
Varicose Veins
Blood Clots
Lung Disease
Difficulty Breathing
Cancer
Surgery
On Medication
Fatigue
Back Pain
Neuritis or Neuralgia
Sciatica or Lumbago
Leg Pain
Allergies

Please Explain:

_____
_____
_____
_____
_____

Circle Areas of Pain/Discomfort



I understand that massage practitioners don't diagnose illness, disease, or any physical or mental disorder. I understand massage is not a substitute for medical examination or diagnosis. I have stated all medical conditions I am aware of.

Signature_____

Date_____