



Touch That
Heals

Springboro Therapeutic Massage

CONFIDENTIAL MEDICAL HISTORY

NAME _____ PHONE (W) _____ (H) _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 DATE OF BIRTH _____ OCCUPATION _____
 DRUG ALLERGIES _____ REFERRED BY _____

DAILY HEALTH HABITS

Have you ever had a professional massage? No Yes If yes, when? _____

Have you ever had an allergic reaction to massage lotions or oils? No Yes _____

Do you have any allergies to nuts? No Yes _____

In reference to your body, where are the present problems that you would like to concentrate on today? Please explain. _____

What are your treatment goals for today? _____

Do you wear contacts, glasses? No Yes

Are you pregnant? No Yes Are you on your menstrual cycle or have cramps? No Yes

Do you smoke tobacco? No Yes If yes, how much per day? _____

MEDICAL AND SURGICAL HISTORY

Are you currently taking any prescribed medication? No Yes If yes, please list. _____

Have you ever had any surgery? No Yes If yes, please explain. _____

Have you ever had any major illness, trauma, or broken bones? No Yes If yes, please explain. _____

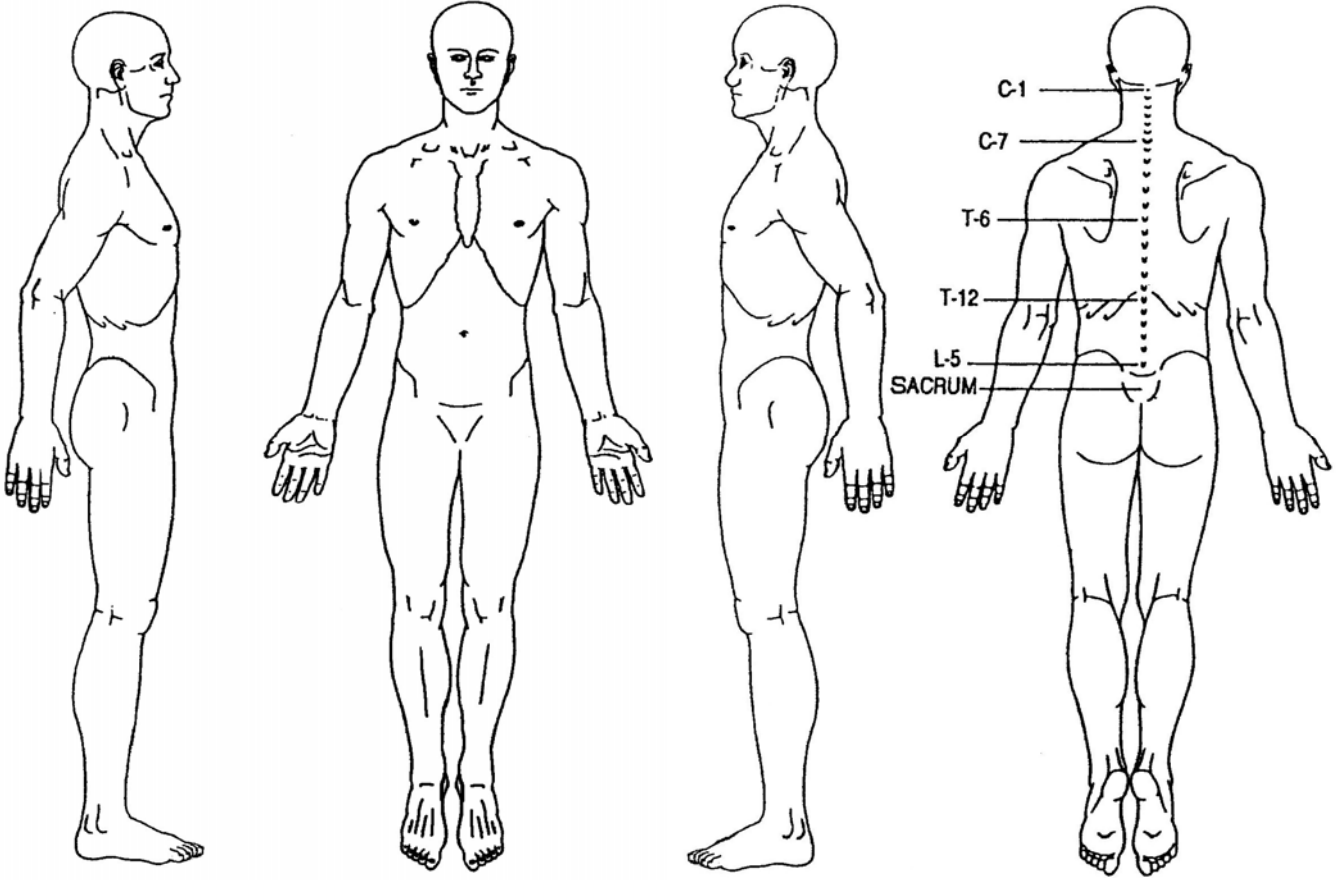
Have you previously had, or do you now have any of the following medical problems?

- | | Past | Current | |
|-----|--------------------------|--------------------------|-----------------|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | HEADACHES |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | T.M.J. |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | NECK PAIN |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | MUSCLE PAIN |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | BACK PROBLEMS |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | FIBROMYALGIA |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | HEART DISEASE |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | HYPERTENSION |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | STROKE |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | KIDNEY PROBLEMS |

- | | Past | Current | |
|-----|--------------------------|--------------------------|-------------------|
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | DIABETES |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | ASTHMA |
| 13. | <input type="checkbox"/> | <input type="checkbox"/> | ARTHRITIS |
| 14. | <input type="checkbox"/> | <input type="checkbox"/> | CANCER |
| 15. | <input type="checkbox"/> | <input type="checkbox"/> | ULCERS |
| 16. | <input type="checkbox"/> | <input type="checkbox"/> | DEPRESSION |
| 17. | <input type="checkbox"/> | <input type="checkbox"/> | SLEEPING PROBLEMS |
| 18. | <input type="checkbox"/> | <input type="checkbox"/> | SKIN DISORDERS |
| 19. | <input type="checkbox"/> | <input type="checkbox"/> | BLOOD CLOTS |
| 20. | <input type="checkbox"/> | <input type="checkbox"/> | VARICOSE VEINS |

Back page to be filled in by therapist. Client to sign bottom of back page.

TO BE FILLED IN BY THERAPIST



Back

- Suboccipitals
- Levator Scapulae
- Trapezius
- Rhomboids
- Infraspinatus
- Supraspinatus
- Teras Minor
- Teras Major
- Subscapularis
- Serratus Posterior Superior
- Latissimus Dorsi
- Erector Spinae
- Gluteus Maximus

- Gluteus Medius
- Gluteus Minimus
- Deep Rotators (Piriformis)
- Quadratus Lumborum
- Deep Paraspinals

Arm

- Anterior Deltoid
- Medial Deltoid
- Posterior Deltoid
- Biceps Brachii
- Triceps Brachii
- Brachialis
- Coracobrachialis

- Spinator
- Forearm Flexors
- Forearm Extensors
- Hand Flexors
- Hand Extensors

Supine Legs

- Quadriceps
- Tensor Fasciae Latae
- Iliotibial Tract
- Iliopsoas
- Tibialis Anterior

Prone Legs

- Hamstrings

- Gastrocnemius
- Soleus
- Achilles Tendon

Supine Trunk

- Pectoralis Major
- Pectoralis Minor
- Serratus Anterior

Therapist Notes _____

I understand that the massage / bodywork that I receive is provided for the basic purpose of relaxation, stress reduction, and relief of muscular tension. The information above is provided for my protection.

I further understand that the massage / bodywork should not be construed as a substitute for medical examination, diagnosis, treatment or prescription for any of the conditions listed above.

Signed: _____ **Date:** _____