Atlanta Colonic & Massage

# Complete for Therapeutic Massage

**Have you ever received a professional massage: No ☐ Yes ☐ If Yes, how long ago: ________________**

**What is your primary area of pain/discomfort: ________________________________________________**?

**When did you first notice this condition: ________________________________________________**?

**When is this condition is most pronounced? AM☐ PM☐ Both☐**

**List any activities which aggravate this condition: ________________________________________________**

**List any other areas of pain, concern or any additional information NOT listed previously, which may be relevant to your visit today: ________________________________________________**

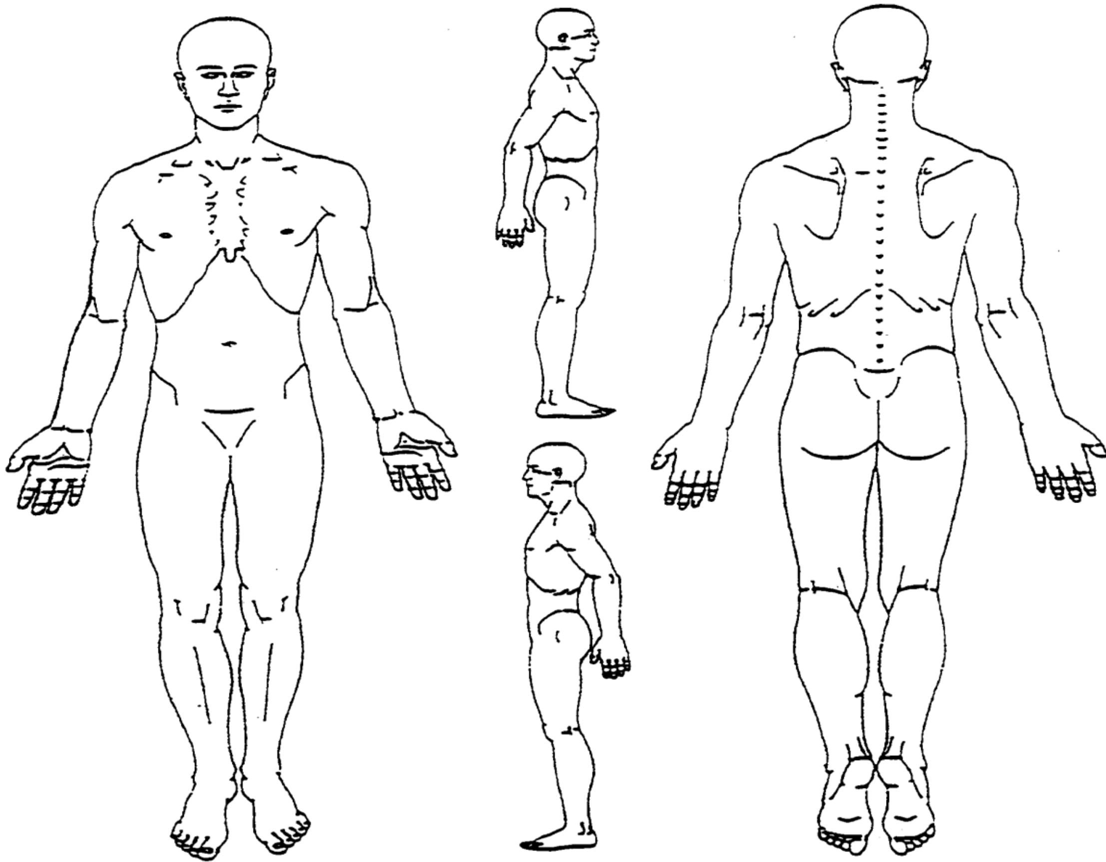
**Are there any particular area(s) of your body you wish the Therapist to avoid?** (Example: due to injury or sensitivity):________________________________________________

Please indicate all body conditions you have experienced. Mark **C** for current or **P** for past.

| | **Joint/Soft Tissue Pain:** | | | | **Cardiovascular:** | | |
|---|---|---|---|---|---|---|---|
| | Upper Back | | Feet | | High Blood Pressure | | Palpitations |
| | Mid-Back | | Hips | | Low Blood Pressure | | Varicose Veins |
| | Lower Back | | Jaw | | Heart Disease | | Swollen Ankles |
| | Degenerative Discs | | Neck | | Heart Attack | | Poor Circulation |
| | Shoulders | | Legs | | Phlebitis | | Heart Murmur |
| | Arms | | Other: _______________ | | Stroke / CVA | | Pacemaker |
| | | | | | | | |
| | **Skin** | | **General:** | | | | **Eye, Ear, Nose, Throat:** |
| | Rashes | | Fainting | | Numbness | | Allergies |
| | Itching | | Dizziness | | Tingling | | Frequent Colds |
| | Bruise easily | | Loss of Sleep | | Paralysis | | Glasses or Contacts |
| | Dryness | | Fatigue | | Headaches (Frequent) | | Hearing Aid/Loss |
| | Boils | | Nervousness | | Migraines | | Sinus Infection |
| | Other ___________ | | Rapid Weight Loss/Gain | | Other: _____________ | | Swollen Glands |
| | **Infections:** | | **Digestive:** | | **Reproductive: (Females)** | | **Respiratory:** |
| | Hepatitis | | Ulcer | | Pregnant: Due_______ | | Chronic Cough |
| | Tuberculosis | | Belching/Gas | | Painful Menstruation | | Bronchitis/ Asthma |
| | Flu | | Constipation | | Heavy Flow | | Hay Fever /Allergies |
| | HIV | | Diarrhea | | Swollen Breasts | | Difficulty Breathing |
| | Herpes | | Nausea | | Menopausal | | Emphysema |
| | Athlete's Foot | | Vomiting | | Birth control, Type | | Pneumonia |
| | **Other Conditions**: | | | | | | |
| | Neurological Conditions | | Smoking | | Hemophilia | | |
| | Epilepsy | | Arthritis | | Kidney Problems | | |
| | Diabetes/Onset | | Anaphylaxis: | | Bladder Problems | | |
| | Cancer | | Vision Loss | | Other: ______________ | | |
| | Insomnia | | Hearing Loss | | | | |

©2017 Atlanta Colonic & Massage LLC

# Please mark any areas of discomfort with an X



## Massage Therapy Acknowledgement

I have discussed all checked contraindications, if any, with the therapist. I understand the massage I receive is provided for sole purpose of relaxation, stress reduction, relief of muscular tension, spasm or pain, or improvement of circulation. If I experience any pain or discomfort during this session, I will immediately inform the therapist so pressure and/or strokes may be adjusted to my level of comfort. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing discussed during session(s) given should be construed as such. Massage therapy may be contraindicated under certain medical conditions.

Atlanta Colonic and Massage does not claim to diagnose treat or cure any condition, illness or disease.

By my signature below, I certify and affirm that I have listed all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile, and understand that there shall be no liability on the therapist's part should I fail to do so.

**Client Printed Name:** ___________________________________________

*Last* *First* *MI*

**Client Signature:** ___________________________________________ ________________

*(for clients under age of 18, signature of parent/legal guardian required)* *Date*

©2017 Atlanta Colonic & Massage LLC