Enumclaw Massage Therapy
Mike Gibbons, LMT
License #: MA 13609
2355 Griffin Avenue, Suite A, Enumclaw, WA 98022
360-259-2895 Fax: 360-272-9416

PERSONAL HEALTH INFORMATION

PERSONAL DATA

Name: _____ Date:_____ Referred By:_____

Address: _____ Phone – Best #:_____

City/State/Zip:_____ OK to text appointment times: ☐ Yes ☐ No

E-mail: _____

Date of Birth:_____ Occupation/Employer:_____

Primary Health Care Provider: _____

Permission to consult with primary provider? Please initial if yes. ☐ Yes: _____ ☐ No

Emergency contact:_____ Relationship:_____ Phone:_____

MASSAGE HISTORY/TREATMENT INFORMATION

Have you ever received a professional massage? ☐ Yes ☐ No If yes, frequency _____
Date of last massage _____

What results do you want from your massage session?

_____

_____

Prioritize the areas of your body that you would prefer to be massaged._____

_____

Are you currently seeing a medical practitioner? Please explain if yes. _____

List stress reduction and exercise activities. Include frequency._____

List current medications, including aspirin, ibuprofen, etc._____

_____

PREVIOUS HISTORY

(Include year and treatment received)

Surgeries:_____

_____

Accidents:_____

_____

_____

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HEALTH HISTORY

MUSCULO-SKELETAL

- ❑ Bone or joint disease: _____
- ❑ Tendinitis: _____
- ❑ Bursitis: _____
- ❑ Broken/fractured bones: _____
- ❑ Arthritis: _____
- ❑ Sprains/strains: _____
- ❑ Lower back, hip, leg pain: _____
- ❑ Neck, shoulder, arm pain: _____
- ❑ Headaches/head injuries: _____
- ❑ Spasms/cramps: _____
- ❑ Jaw pain/TMJ: _____
- ❑ Lupus: _____
- ❑ Other: _____

CIRCULATORY

- ❑ Heart condition: _____
- ❑ Varicose veins: _____
- ❑ Blood clots: _____
- ❑ High blood pressure: _____
- ❑ Low blood pressure: _____
- ❑ Lymphedema: _____
- ❑ Breathing difficulty: _____
- ❑ Sinus problems: _____
- ❑ Allergies: _____
- ❑ Other: _____

SKIN

- ❑ Allergies: _____
- ❑ Rashes: _____
- ❑ Athletes foot: _____
- ❑ Warts: _____
- ❑ Prone to Bruising: _____
- ❑ Other: _____

INFECTIOUS DISEASE

- ❑ Disease name(s): _____
  _____
  _____

DIGESTIVE

- ❑ Constipation: _____
- ❑ Gas/bloating: _____
- ❑ Diverticulitis: _____
- ❑ Irritable bowel syndrome: _____
- ❑ Other: _____

NERVOUS SYSTEM

- ❑ Herpes/shingles: _____
- ❑ Numbness/tingling: _____
- ❑ Chronic pain: _____
- ❑ Fatigue: _____
- ❑ Sleep disorders: _____
- ❑ Other: _____

REPRODUCTIVE

- ❑ Pregnant? Stage: _____
- ❑ PMS: _____
- ❑ Other: _____

OTHER

- ❑ Cancer/tumors: _____
- ❑ Diabetes: _____
- ❑ Eating disorders: _____
- ❑ Depression: _____
- ❑ Drug/alcohol addiction: _____
- ❑ Caffeine addiction: _____
- ❑ Nicotine addiction: _____

It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time during the treatment I feel my well-being is being compromised.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

SIGNATURE: _____ DATE: _____

Signature of Parent or Legal Guardian (if client is a minor)

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Release of Medical Records

I _____ authorize the release of my medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements and other written information to my attorneys, health care providers, and insurance case managers, for the purposes of processing my claims.

Signature: _____ Date: _____

Signature of Parent or Legal Guardian (if client is a minor)