M.T. Wellness Clinic
1151 Bethel Road, Suite 302
Columbus, OH 43220

Personal Health Information

Name: ______________________ Date: __________ Date of Birth______________________

Address: ______________________ Phone-Day: ______________________

City/State/Zip: ______________________ Phone-Eve: ______________________

E-mail:______________________ May we put you on our e-list? (Mailings usually monthly) ❑ Yes ❑ No

Occupation / Employer: ______________________ Phone: ______________________

Referred by: ______________ Phone:__________ Address: ______________________

Emergency contact: ______________ Relationship:__________ Phone:______________________

Release of Information

We recognize the great importance of the **confidential information** you share about your health with your therapist. No information from your file will be shared with outside parties without your written consent. It is sometimes necessary for the therapists within the clinic to consult with each other about your course of treatment. This is done to provide you with the highest quality treatment. The sharing of information will always remain within this office.

I give my permission for M.T. Wellness Clinic to provide information that pertains to my massage therapy care to my: referring physician, primary care physician, referral source (physical therapist, dentist, personal trainer, etc. identified above) and insurance company/ payer.

Referring Physician Name: ______________________ Phone:______________

Address/City/State/Zip: ______________________

Primary Care Physician Name: ______________________ Phone:______________

Address/City/State/Zip: ______________________

Your signature: ______________________ Date:______________

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 sessions? ______________________

____

Are you currently seeing a medical practitioner or specialist for this pain? Please explain if yes. ❑Yes ❑ No ______________

____

Are you currently seeing a psychotherapist or are you attending regular support group meetings? Please explain if “Yes”. ❑Yes ❑ No

____

List stress reduction and exercise activities. Include frequency. ______________________

____

List **current medications**, including aspirin, ibuprofen, etc. ______________________

____

PREVIOUS HISTORY (Include year and treatment received)

Surgeries: ______________________ Accidents: ______________________

HEALTH HISTORY

Please check all that apply to you. If you leave an area blank, you are stating that you have no problems in that area.

MUSCULO-SKELETAL

__ bone or joint disease______________________
__ tendonitis______________________
__ bursitis______________________
__ broken/fractured bones______________________
__ arthritis______________________
__ sprains/strains______________________
__ low 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______________________

INFECTIOUS DISEASE

__ disease name(s):______________________
____
____
____
____
____

SKIN

__ allergies______________________
__ rashes______________________
__ athletes foot______________________
__ warts______________________
__ other______________________

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______________________
__ nicotine/caffeine addiction______________________

Consent to Treat

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 increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like 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:______________________