

# Nora Avenue

## Massage and Therapies Patient Information

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
E-Mail: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you ever had Massage Therapy before?  Yes  No  
Are you currently under a Doctor's, Chiropractor's or Physical Therapist's care?  Yes  No  
If YES, for what condition? \_\_\_\_\_

Do we have permission to contact your doctor on the advisability of massage?  Yes  No  
How did you discover this service? \_\_\_\_\_

Please list any medications you are taking: \_\_\_\_\_

**Please mark with an (X) all conditions that apply. Mark (P) for past conditions and indicate how many years ago.**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> tension headaches _____ | <input type="checkbox"/> whiplash _____                            | <input type="checkbox"/> congestive heart failure _____ |
| <input type="checkbox"/> migraines _____         | <input type="checkbox"/> osteoarthritis _____                      | <input type="checkbox"/> rheumatoid arthritis _____     |
| <input type="checkbox"/> varicose veins _____    | <input type="checkbox"/> cancer _____                              | <input type="checkbox"/> circulatory problems _____     |
| <input type="checkbox"/> stroke _____            | <input type="checkbox"/> disc problems _____                       | <input type="checkbox"/> spinal fusions _____           |
| <input type="checkbox"/> osteoporosis _____      | <input type="checkbox"/> recent surgery _____                      | <input type="checkbox"/> infectious disease _____       |
| <input type="checkbox"/> diabetes _____          | <input type="checkbox"/> recent injury _____                       | <input type="checkbox"/> high/low blood pressure _____  |
| <input type="checkbox"/> fibromyalgia _____      | <input type="checkbox"/> heart attack _____                        | <input type="checkbox"/> hip/knee replacement _____     |
| <input type="checkbox"/> jaw pain/TMJ _____      | <input type="checkbox"/> allergies to nut based oils/lotions _____ |   |

Please explain any conditions noted above *or if you have any other conditions not listed.*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have completed the above information to the best of my knowledge. I understand that massage therapy does not replace a physician's care. I understand that the therapist may refuse massage due to certain medical contraindications, unless the treating physician advises us in writing that massage will be beneficial. I understand that the therapist also reserves the right to refuse or discontinue massage due to unethical behavior or misconduct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_