Korman Relief & Wellness Center 16954 Toledo Blade Blvd. Port Charlotte, Fl. 33954
941-629-6700

Massage Therapy Health History

Your answers to the following questions are confidential. The information requested is important to our massage therapist in order to provide you with the best care. Please be honest and accurate with the information given.

Date_____/_____/_____

Name_____ Birth date_____/_____/_____ Age_____ Gender: M / F

Address _____ City _____ State_____ Zip_____

Cell Phone _____ Home Phone _____Work Phone _____

E-mail Address (please print) _____

Occupation _____

Referred by _____

Are you pregnant? Yes / No If yes, how many weeks? _____

What do you do for exercise?_____

How often do you exercise? _____

What do you do for relaxation? _____

Have you ever received a professional massage? Yes / No

Previous experience with massage _____

_____

List any traumas you have had to your body from an accident, fall, etc. Please include ALL muscle, bone, or joint injuries even if not recent. _____

_____

_____

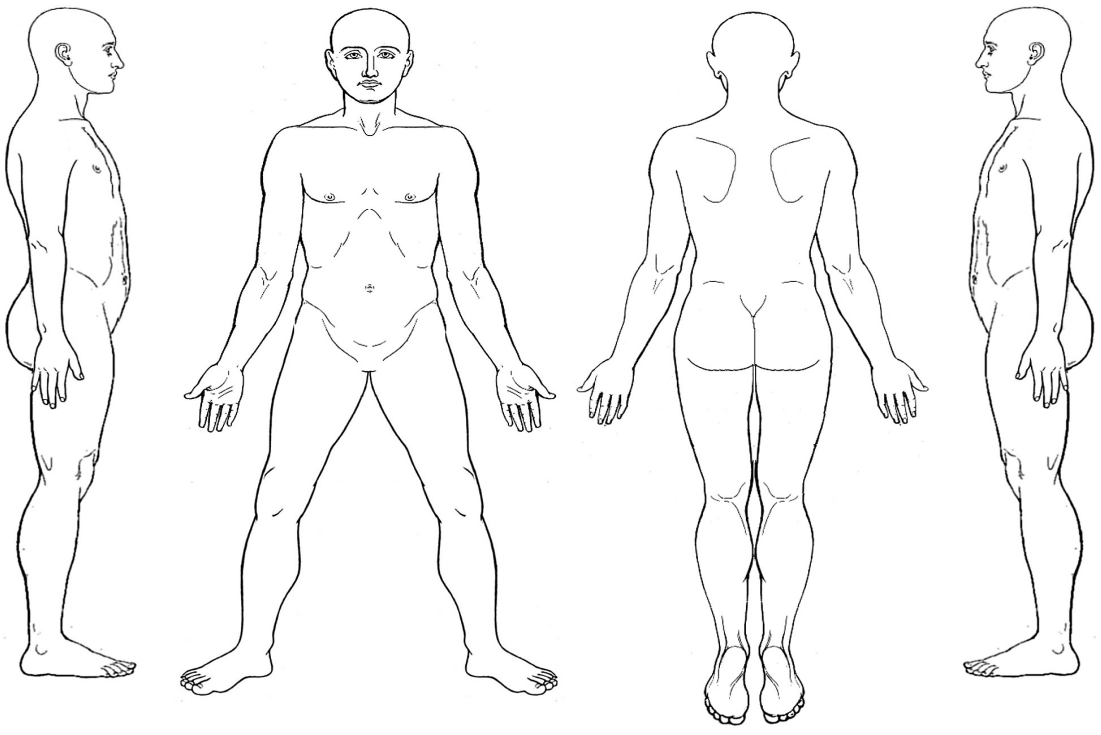
_____

Reason(s) for your massage today _____

_____

_____

PLACE AN “X” ON THE AREAS BELOW WHERE YOU FEEL DISCOMFORT OR WOULD LIKE YOUR THERAPIST TO FOCUS



Korman Relief & Wellness Center
Laura R. Korman, DC, DACBN
16954 Toledo Blade Blvd.
Port Charlotte, Fl. 33954

Massage Therapy Health History

Check below *all* conditions that apply to either you or your family members:

"X" = Conditions YOU have *at present*

"P" = Conditions you've had in the *past*

"F" = History of a condition in your *family*

___ Headaches / Migraines
___ Vision Problems / Contacts
___ Hearing Problems / Deafness
___ Head or Face Injuries
___ Sinus Problems
___ Dental Bridges / Braces
___ Jaw Pain / TMJ
___ Asthma / Lung Problems
___ Constipation / Diarrhea

___ Hernia
___ Birth Control / IUD
___ Chronic Pain
___ Muscle / Joint Pain
___ Muscle / Joint Injuries
___ Numbness / Tingling
___ Sprains / Strains
___ Arthritis / Tendonitis
___ Cancer / Tumors

___Spinal Column Disorders
___Abdominal / Digestive Problems
___Pregnant
___Heart / Circulatory Problems
___Chronic Fatigue
___Stress / Tension
___Depression / Anxiety
___Sleep Difficulties / Insomnia
___Allergies / Sensitivities
(As explained below)

___Rash
___Athlete's Foot / Fungus
___Infectious Disease
___Blood Clots
___Varicose Veins
___High / Low Blood Pressure
___Diabetes
___Other Medical Conditions:
_____
_____

Please explain any issues noted above _____

_____

_____

Is there anything else your therapist should know? _____

_____

Allergies (include foods, medications, lotions, oils, creams, aromatherapy products, etc. _____

_____

_____

MEDICATIONS	STRENGTH (MG,ML,ETC)	HOW MANY TIMES/DAY	DATE BEGAN
1			
2			
3			
4			
5			

The following reactions sometimes occur during massage and are normal responses to relaxation and/or touch. You need not be embarrassed or feel the need to suppress these naturally occurring responses: movement or release of intestinal gas, crying or laughing, strong emotions, sighing, groaning, yawning, softening of muscle tissue, cognitive or felt memories, stomach gurgling, the need to move or change position.

At *any* time during your session, please let your therapist know if there is something that can be done to make you feel more comfortable.

I understand that the services provided are not a replacement for medical or psychological care, and that any information provided is neither prescriptive nor diagnostic in nature and is for educational purposes only.

I give my permission for the LMT providing my care to discuss information pertinent to my condition(s) and treatment with my other health care provider as necessary.

PATIENT / GUARDIAN SIGNATURE_____**DATE** _____/_____/_____