Riverstone Massage Therapy
505 Waltham Street
West Newton, MA 02465
617-843-5229

Personal Information:

Name ______________________ Phone (Day) ______________ Phone (Eve) ______________

Address ____

City ______________________ State ________ Zip ____________

Email ______________________ Date of Birth __________ Occupation ______________

Emergency Contact ______________________ Phone ______________________

Referred By ______________________________

The following information will be used to help plan safe and effective massage sessions. Please answer all questions to the best of your knowledge.

1. Have you had a professional massage before? Yes No

2. Do you have any difficulty lying on your front, back or side? Yes No

3. Do you have any allergies to oils, lotions, or ointments? Yes No

4. Are you wearing ( ) contact lenses ( ) dentures ( ) a hearing aid?

5. Do you sit for long hours at a workstation, computer or driving? Yes No
   If yes, please describe ____

6. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
   If yes, please describe ____

7. Do you experience stress in your work, family, or other aspect of you life? Yes No
   If yes, how do you think it has affected your health?
   ( ) muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other ______________

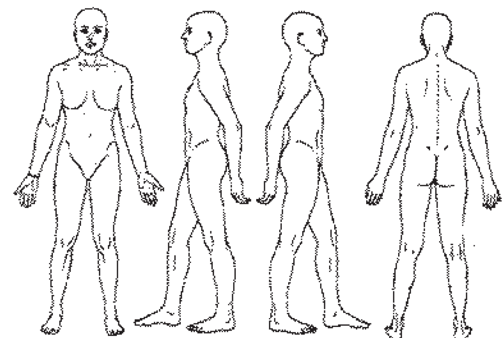
8. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No
   If yes, please identify ____

9. Do you have any particular goals in mind for this massage session? Yes No
   If yes, please explain ____

Medical History

Identify any areas where you feel pain or discomfort:

PPP – Areas where you are experiencing pain
XXX – Areas that are tight
TTT – Areas that are ticklish



10. Are you currently under medical supervision? Yes No

11. Do you see a chiropractor? Yes No If yes, how often? ______________________

12. Do you see a physical therapist, acupuncturist or other body worker? Yes No

13. Are you currently taking any medication? Yes No
If yes, please list ____

14. Please check any condition below that applies to you:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) arthritis/osteoarthritis/tendonitis
( ) recent or past accident or injury
( ) recent or past fracture
( ) recent or past surgery
( ) artificial joint
( ) sprains/strains
( ) current fever
( ) swollen glands
( ) allergies/sensitivity
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) atherosclerosis
( ) phlebitis
( ) deep vein thrombosis/blood clots
( ) joint disorder/rheumatoid
( ) osteoporosis
( ) epilepsy
( ) headaches/migraines
( ) cancer
( ) diabetes
( ) decreased sensation
( ) back/neck problems
( ) fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) tennis elbow
( ) pregnancy - if yes, how many months? ________

Please explain any condition that you have marked above: ______________________________
____

15. Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you? ______________________________
____
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Please take a moment to carefully read the following statement and sign where indicated.

I understand that the massage I receive is provided for the purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapist are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated 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. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client signature ______________________________ Date ________________