Optimus – The Center for Health – 200 E Southampton Ave – Columbia MO 65203– Janene Sun (LMT) – (573) 999-0451 – Janene@sunsportsmassage.com

Please fill out the following information to the best of your knowledge

Name:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Telephone: (home)_____ (other) _____ Birthday:_____
Occupation:_____ Email:_____
How did you hear of this therapist?_____
Physician:_____ Chiropractor:_____

Are you under your physician's care at this time? Yes No
If yes, for what _____
_____

Are you under your chiropractor's care at this time? Yes No
If yes, for what reason?_____
_____

Have you received a massage in the past? Yes No
Please rate your experience: Beneficial Neutral Not beneficial

For what reason do you seek massage therapy?_____
_____
Is this the result of an injury? Yes No
If yes, for what reason?_____
_____

Are you currently experiencing any of the following? (Please check all that apply.)

___ General muscle stiffness of soreness
___ Headaches
___ Neck pain or stiffness
___ Shoulder pain or restriction
___ Pain or soreness between the shoulder blades
___ Mid-back pain
___ Low-back pain
___ Sore, stiff or aching hips
___ Nerve pain (tingling) down the legs
___ Leg pain
___ Foot problems
___ Restricted range of motion in any area of your body
___ Pain when performing certain motions
___ Numbness or tingling in either hand or arm

If you checked the above, please give a brief description:_____
_____
_____

Have you experienced any of the above symptoms during the last month? Yes No
If yes, please explain: _____
_____

Have you ever been in a minor or major car accident and suffered an injury from it? Yes No

If yes, when was/were the accident(s)? _____

Please describe the accident(s) and the injury(ies):_____

_____

_____

Have you ever broken a bone? Yes No

If yes, when? _____ Please describe the break and how it occurred:_____

_____

_____

Have you ever had surgery? Yes No

If yes, when? _____ Please give a brief description:_____

_____

_____

Do you wear contact lenses? Yes No

Do you wear dentures? Yes No

Do you have any skin allergies? Yes No

Do you have any recent cuts or open sores? Yes No

If yes, where?_____

Are you pregnant? Yes No

Have you ever given birth? Yes No

If yes, how would you describe the birthing experience? Easy Hard

Have you ever been diagnosed as having scoliosis? Yes No

If yes, to what degree?_____

Do you have any blood clots or varicose veins (more than spider veins)? Yes No

If yes, where? _____

Do you have arthritis? Yes No

If yes, where? _____

Do you exercise regularly or participate in any sports? Yes No

If yes, what kind and how often? _____

_____

Do you take any prescribed medications? Yes No

If yes, please list the reason:_____

_____

Do you have any heart or blood pressure problems? Yes No

If yes, please describe:_____

_____

Do you have any other medical conditions I should be aware of before giving you a massage therapy treatment? Yes No

If yes, please describe:_____

_____

This massage therapist does not diagnose illness, disease or any other physical or mental disorder. Neither will she prescribe medical treatment or pharmaceuticals. She will not perform any high velocity, low amplitude spinal manipulations. his massage treatment is not a substitute for a medical examination or a diagnosis.

Since my massage therapist should be aware of existing physical conditions, I have stated all of my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Client Signature: _____ Date: _____

Therapist signature: _____ Date: _____