Apex Massage

3410 Frankfort Avenue, Louisville, KY 40207
(502) 895-1262

Name_____Date_____E-mail_____
Address_____City_____State_____Zip_____
Phone_____ Occupation_____ Date of Birth_____
Who referred you to this office? Name:_____
*Drove By___ Yellow Pages___ Website___ Mailer___ Other*_____

Present Symptoms: What is your major complaint or condition you want to improve?
_____
When did you first notice this?_____
Is it progressively getting worse or better?_____
Has there been a medical diagnosis?_____
List all medications you currently take_____
Who is your regular health care provider?_____

Check if you have had recent problems with any of the following:

- Lymphedema
- Fibromyalgia
- Diabetes
- Asthma
- Heart condition
- Chest pain
- Shortness of breath
- Sciatica
- Scoliosis
- Arthritis
  - Where?_____
- Osteoporosis
- Bursitis
  - Where?_____
- Tendonitis
  - Where?_____
- Varicose veins
- Blood clots
  - Where?_____
- Skin condition/Rash
  - Where?_____
- Infectious condition
  - Where?_____
- High blood pressure
  - If yes, any medication?
  - Please list_____
- Sinus/Allergies
- Seizures/Convulsions
- Dizziness/Fainting
- Numbness/Tingling
  - Where?_____
- Other?_____

Head:

- Jaw pain/TMJ
- Grind teeth
- Lights bother eyes
- Ringing in ears
- Loss of balance or dizziness
- Headaches
  - Where?_____

Neck:

- Stiffness
- Pain with movement
- Grinding/popping
- Whiplash
- Other?_____

Shoulders:

- Pain with movement
- Can't raise arm
- Grinding/Popping
- Dislocations
- Other?_____

Arms and Hands:

- Hands cold
- Loss of grip strength
- Shooting pains
- Carpel Tunnel Syndrome
- Thoracic Outlet Syndrome
- Tennis Elbow
- Other?_____

Upper Back:

- Stiffness
- Spasms/Cramps
- Pain between Scapulas

Mid/Low Back:

- Pain with movement
- Spasms/Cramps
- Other?_____

Hip, Legs, & Feet:

- Spasms/Cramps
- Pain in buttocks/hip
- Shooting pains
- Hip replacement
- Knee pain
- Other?_____

Abdomen:

- Nausea
- Gas
- Constipation
- Irritable Bowel Syndrome
- Tenderness
- Other?_____

Females:

- Pregnant
- # of months_____
- Menstrual pain
- Menopause
- Other?_____

Massage Therapy Informed Consent

I, (please print name) _____, understand that massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, and improve circulation. Any other intended purpose for massage therapy should be listed below:

_____

_____

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is NOT a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not a part of massage therapy.

I have informed the massage therapist of all known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. Any conditions not listed on the front sheet?_____

I have received a copy of the therapist's policies; I understand them and agree to abide by them.

_____ _____

Client Signature Date