Soothing Sensations, LLC
5446 N. Academy Blvd., Suite 104
Colorado Springs, CO 80918
719-232-0157

PERSONAL HEALTH INFORMATION

PERSONAL DATA

Name: ____ Date: _________________________

How Did You Hear About Us: ____

Would you like to be on our mailing list for Newsletters and Specials? ☐ No ☐ Yes, please enter email address below

Email Address: ____

Address: ____ Phone – Day: _____________________

City/State/Zip: ____ Phone – Eve: ______________________

Occupation/Employer: ____ Birthday (Month/Day): _______________

Emergency Contact: ____ Phone: ___________________________

MASSAGE HISTORY/TREATMENT INFORMATION

Have you ever received a professional massage? ☐ Yes ☐ No If yes, frequency: _________ Date of last massage: ________

What results do you want from your massage sessions? ____

____

Prioritize the areas of your body that you would prefer to be massaged. ______________________________________

____

Are there any areas of your body that you prefer NOT be massaged? ____

List **ANY** current medications you are taking, including aspirin, ibuprofen, etc. ____________________________________

____

List **ANY** known allergies (including food, medication, etc): ____

____

PREVIOUS HISTORY (Include year and treatment received)

Injuries:____

____

Accidents:____

____

PLEASE COMPLETE THE BACK SIDE

HEALTH HISTORY CONTINUED

MUSCULO – SKELETAL

_____ bone or joint disease ________________________________

_____ tendentious _______________________________________

_____ bursitis ____

_____ broken/fractured bones ______________________________

_____ arthritis ____

_____ sprains/strains _____________________________________

_____ low back, hip, leg pain ______________________________

_____ neck, shoulder, arm pain _____________________________

_____ headaches/head injuries ______________________________

_____ spasms/cramps _____________________________________

_____ jaw pain/TMJ ______________________________________

_____ lupus ____

_____ other ____

CIRCULATORY

_____ heart condition _____________________________________

_____ varicose veins ______________________________________

_____ blood clots ____

_____ high blood pressure __________________________________

_____ low blood pressure ___________________________________

_____ Lymphedema ____

_____ breathing difficulty __________________________________

_____ sinus problems ______________________________________

_____ other ____

INFECTIOUS DISEASE

_____ disease name (s): ____________________________________

____

____

SKIN

_____ rashes ____

_____ athletes foot _______________________________________

_____ warts ____

_____ other ____

DIGESTIVE

_____ constipation ____

_____ gas/bloating ____

_____ diverticulitis _______________________________________

_____ irritable bowel syndrome ______________________________

_____ other ____

NERVOUS SYSTEM

_____ herpes/shingles _____________________________________

_____ numbness/tingling ___________________________________

_____ chronic pain ____

_____ fatigue ____

_____ sleep disorders ______________________________________

_____ other ____

REPRODUCTIVE

_____ pregnant? Stage _____________________________________

_____ PMS ____

_____ other ____

OTHER

_____ cancer/tumors ______________________________________

_____ diabetes ____

_____ eating disorders ____________________________________

_____ depression ____

_____ drug/alcohol addiction ________________________________

_____ nicotine/caffeine addiction _____________________________

It is my choice to receive massage therapy. I realize that the treatment is being given for the well being of my body and mind. This included stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my therapist any time I feel like my well being is being compromised.

I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all of my medical conditions that I am aware of and will update the massage therapists of any changes in my health status.

SIGNATURE: ____ **DATE**: ___________________________