Alice Beloved, BA, CMT – CONFIDENTIAL MEDICAL HISTORY FORM

Name:_____

Mailing Addr:_____

Contact Phone(s):_____**cell:**_____*(text OK?__yes___no)*

Emergency Contact: _____

Email *(for communication purposes only)* _____

Please Place "X" next to Each Area of Concern:

____Spine (___Upper/thoracic, ___Neck, ___Lower Back, ___Sacrum/Coccyx)

____Hands (___ Wrists, ___ Fingers/Thumb)

____Feet (___Toes, ___ Ankle(s))

____Shoulders (___ A/C Joint, ___Trapezius, ___Scapular/Rhomboid Area)

____Arm(s) (___Bicep(s), ___Triceps) ____Elbow, ____Forearm(s)

____Torso (___ Rib(s), ___Pelvis, ___Hip Joint(s)

____ Chest (___ Clavicle, ___ Sternum, ___Xyphoid Proc.)

____ Internal Organs *(Please give details below)*

____ Upper Legs (___Quadriceps, ___Hamstrings, ___IT Band)

____ Lower Legs (___ Calves, ___Shins)

Other Concerns:

____ Numbness, Burning, Tingling *(Please give details below)*

____ Skin Problems *(Please give details below)*

____Allergic to: _____

____Scent Sensitivity *(Please note any Fragrances, or Essential Oils to be avoided)*

____Medical Diagnoses: _____

____ Prescribed Medications, and what issues they address:

_____

Other Concerns/ Details:_____

_____

_____

Please See Back of Form, Read Info, Date and Sign ⟶

By signing this form, I acknowledge the following:

I understand that Therapeutic Massage is given here for the express purpose of:

****Stress Reduction,** ****Temporary Relief of Muscle Pain or Spasm,**

****Improvement of Blood and Lymph circulation, and**

****Improvement of Muscle and Connective Tissue Function.**

The Massage Therapist DOES NOT diagnose illness, prescribe medication, or provide other medical treatment. It has been made clear to me that Therapeutic Massage is NOT a substitute for medical examination or diagnosis, and it is recommended that I consult a qualified medical professional for such services.

I have read all of the above information, and have, to the best of my ability, provided complete and accurate information regarding any physical, or other condition which may be negatively impacted by massage techniques.

The Massage Therapist RESERVES THE RIGHT to DISCONTINUE or REFUSE treatment at ANY TIME, and MAY ASK for a PHYSICIAN'S WRITTEN RELEASE prior to providing any massage services.

All information contained herein is considered CONFIDENTIAL, and will NOT be shared with ANY individual without my EXPRESS WRITTEN CONSENT .

_____

Signature *Date*

_____

Print Name