shine
HOLISTIC WELLNESS CENTER

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Birth Date: _____ Marital Status: ❑ Married ❑ Single ❑ Divorced

Occupation: _____ Employer: _____

Referred by: _____

Emergency Contact: _____ Phone: _____

Physician: _____ Phone: _____

Massage Information

First professional massage: ❑ Yes ❑ No; how frequently do you have a massage: _____

Medical Information

List accidents/injuries, hospitalizations, and surgeries: when they occurred and treatment received.

_____

_____

_____

Any lingering effects from the above or do you feel you have recovered?

_____

_____

_____

Chronic, ongoing pain? ❑ No ❑ Yes, please describe any care or treatment you receive.

_____

_____

Do activities affect the pain? ❑ No ❑ Yes, please describe.

_____

_____

Are you currently being treated medically or taking prescribed drugs? ❑ No ❑ Yes, please describe.

_____

_____

*Shine Holistic Wellness Center has a 24-hour cancellation policy.

Please list all over the counter supplements and/or herbs taken and why.

_____

_____

_____

History

Musculoskeletal

- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Hypothyroidism
- ☐ Fibromyalgia
- ☐ Chronic Fatigue
- ☐ Gout in: _____
- ☐ Bursitis
- ☐ Plantar Fascitis
- ☐ Cysts/Lipomas
- ☐ TMJ
- ☐ Chronic Headaches
- ☐ Tendonitis
- ☐ Whiplash
- ☐ Strains/Sprains
- ☐ Chronic pain in:
  - ☐ Neck
  - ☐ Low-back
  - ☐ Mid-back
  - ☐ Upper-back
  - ☐ Hip
  - ☐ Arm
  - ☐ Leg
  - ☐ Shoulder
  - ☐ Wrist/Hand
- ☐ On computer more than 2 hrs/day No. of hours: _____

Respiratory

- ☐ Pneumonia
- ☐ Asthma
- ☐ Breathing Problems
- ☐ Sinusitis
- ☐ Other: _____

Digestive

- ☐ Ulcers
- ☐ Colitis
- ☐ IBS
- ☐ Chron's disease
- ☐ Gluten Intolerance
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gallstones
- ☐ Gas/Bloating
- ☐ Chronic Indigestion

Circulatory

- ☐ Heart problems:_____ _____
- ☐ Stroke
- ☐ Palpitations
- ☐ Mitral valve prolapse
- ☐ Anemia
- ☐ Hemophilia
- ☐ Hypertension
- ☐ Low Blood Pressure
- ☐ Peripheral Artery disease
- ☐ Raynaud's disease
- ☐ Varicose veins
- ☐ Blood clots/Phlebitis

Skin

- ☐ Fungal infections
- ☐ Athlete's Foot
- ☐ Impetigo
- ☐ Eczema/Dermatitis
- ☐ Psoriasis
- ☐ Easily irritated skin
- ☐ Other:_____

Nervous System

- ☐ Dizziness
- ☐ ALS
- ☐ Multiple Sclerosis
- ☐ Parkinson's disease
- ☐ Bell's Palsy
- ☐ Neuritis
- ☐ Spinal cord injury
- ☐ Trigeminal Neuralgia
- ☐ Seizures/Epilepsy

Other

- ☐ Diabetes
- ☐ Pregnancy
- ☐ Cancer
- ☐ Kidney disease
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Lupus
- ☐ Postoperative: _____
- ☐ Cystitis
- ☐ High Stress
- ☐ Grieving
- ☐ Anxiety/Panic attacks
- ☐ Bipolar syndrome
- ☐ PMS/Menopause difficulties
- ☐ Poor sleep/Insomnia
- ☐ Allergies affecting:
  - ☐ Facial skin
  - ☐ Body skin
  - ☐ Nose/Sinuses
  - ☐ Eyes
  - ☐ Stomach/Gut
- ☐ Orthopedic pins or plates
- ☐ Other:_____

Exercise

Time/day-week:_____ Activities: _____

_____

The above information is accurate. I understand that Massage Therapists do not diagnose disease or prescribe drugs and that they are not a substitute for medical care. I agree to alert my practitioner of any physical/emotional changes as they occur. I also understand that a missed appointment might incur charges that I must pay.

Signature:_____ Date: _____