This serves to note our beginning and guide our path forward.

Please print, complete, sign, and bring with you.

First Name Last Name Date of birth \_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_\_

Referred by

Email Address Mobile Phone #

Home Phone # Work Phone #

Street Address

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State Zip Code

Emergency contact name Physician’s name

Emergency contact relationship

Physician’s phone # Emergency phone #

Date of initial visit

How would you rate your general health?

Excellent Good

Fair Poor

Have you had a professional massage before?

Yes *(Date of last treatment)*

No

Reason for initial visit…where is your body talking to you?

List any major accidents or surgeries (including dates)

Please tell us about any allergies or hypersensitivities List current medications & the conditions they are treating

**HEAD NECK**

Headaches / migraines Vertigo / dizziness Ringing in ears Hearing loss Vision problems Vision loss

**RESPIRATORY**

Asthma Shortness of breath Chronic cough Bronchitis Emphysema Sinusitis

Frequent colds Smoker

Family history of respiratory difficulties

**NERVOUS SYSTEM**

Sensory loss / change Numbness / tingling

Sciatica Epilepsy

Seizures Multiple sclerosis

**MUSCULOSKELETAL SYSTEM**

Arthritis Family history of arthritis

Osteoporosis Tendonitis Bursitis Jaw pain (TMJ)

Gout

Pins / plates / wires / artificial joint

**REPRODUCTIVE**

Pregnant Given birth

Gynecological problems

**CARDIOVASCULAR**

High blood pressure Low blood pressure

Heart attack Stroke

Heart disease Poor circulation Phlebitis / varicose veins Pacemaker Hemophilia

Chronic congestive heart failure

Family history of cardiovascular problems

**SKIN & INFECTIONS**

Hepatitis HIV / AIDS Herpes Tuberculosis

Lyme disease Infectious skin conditions

**OTHER CONDITIONS**

Cancer Diabetes Unexplained weight loss Digestive conditions Fibromyalgia Chronic fatigue syndrome Depression Anxiety

Psychiatric disorder

Other conditions

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage.

I understand:

* That I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis.
* There is no implied or stated guarantee of the success or effectiveness of individual techniques or series of appointments.
* That my personal health information will be collected and all information that I provide will be kept confidential unless required by law.
* I also consent that my medical information may be shared by the various care providers involved in my care and treatment.
* That this unique therapy may create soreness and pain.

I agree to pay for each session. I understand that Taum doesn't bill insurance. Taum can provide a record of sessions for the client to submit for insurance reimbursement. Treatments may be covered by extended health care plans. I understand that it is my responsibility to confirm the exact details of my coverage.

I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

With any minors, parent or guardian is required to be present during appointment and to enter signature.

Signature: Date: