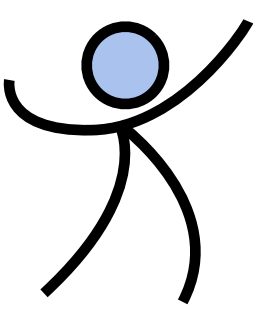

Total Care Physical Therapy

Therapy / Massage / Rehabilitation

Medical Information Form

Patient Name: _____ Email: _____

Age: _____ Gender: M ☐ F ☐ Emergency Contact w/Phone: _____

Have you ever had: Massage ☐ Physical Therapy ☐

If *Yes*, how recently: _____

What medications are you currently taking, if any?

_____

Are you allergic to any foods or medications? Yes ☐ No ☐

If *Yes*, please list: _____

Are there any areas that are sensitive to the touch or points of tension or soreness? Yes ☐ No ☐

If *Yes*, please list: _____

Do you currently have any of the following conditions (check if yes):

☐ Stress	☐ Headaches	☐ Allergies	☐ High Blood Pressure
☐ Seizures	☐ Osteoporosis	☐ Arthritis	☐ Respiratory Problems
☐ Diabetes	☐ Epilepsy or Seizures	☐ Numbness	☐ Joint Swelling
☐ Pregnancy	☐ Bruise Easily	☐ Back Pains	☐ Contagious Diseases
☐ Stabbing Pains	☐ Circulatory Problems	☐ Cancer	☐ Pacemaker

Have you had any injuries or surgeries in the last 5 years (including car accidents, broken bones, etc.)?

If *Yes*, please list: _____

Do you have any other medical conditions we should be aware of? Yes ☐ No ☐

If *Yes*, please list: _____

I understand that the massage/bodywork I receive is provided for the purpose of relaxation and relief of muscular tension. If I receive any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and or strokes can be modified for my level of comfort. I understand that Massage Therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness. I affirm that I have stated all of my known medical conditions and I have honestly answered all of the questions. I agree to keep the therapist updated with any known medical changes, and the therapist should not be liable if I do not do so. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment.

Patient Signature: _____ Date: _____