Alaina Craft, LMT

***This information is kept completely confidential & used only for the sole purpose of our therapeutic relationship.**

First Name:_____ M.I_____ Last Name:_____

Address: _____City: _____State: _____ Zip:_____

Phone(h): _____(w) _____Date of Birth:_____

Employer:_____Occupation:_____

Emergency contact:_____Phone: _____Relationship:_____

E-mail: _____Referred by: _____

Is this your first professional massage? _____If no, how frequently do you get a massage? _____

What do you hope to accomplish from today's massage? _____

If you're aware, list any tension holding spots in your body:_____

Describe any surgeries, hospitalizations, accidents or injuries you have had:

Less than 5 years ago:_____

More than 5 years ago:_____

Do you feel that you have recovered from these events? _____Please explain: _____

Do you have any chronic, ongoing pain that you deal with on a regular basis? _____

Please explain: _____

Describe what activities cause this pain and/or make it worse:_____

Are you receiving any other type of medical treatment?_____Please explain: _____

Please list any medication (vitamins, herbs or pharmaceutical) taken now or at regular intervals (include explanation of what medication is used to treat):_____

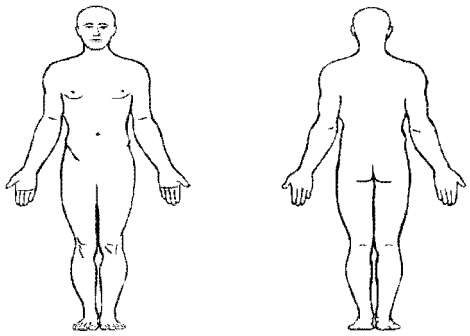
_____

Are you currently under the care of a physician? _____Whom? _____

Please list reason(s):_____

Are there any other health concerns you wish to discuss today?_____

Please indicate where you experience pain on the drawing below



Please check any of the following conditions below that currently affect you or that you have experienced.

The above information is accurate and true to the best

MUSCULOSKELETAL
___ Fibromyalgia
___ Spasms/Cramps
___ Sprains/Strains
___ Osteoporosis
___ Postural Deviations
___ Osteoarthritis/Rheumatoid Arthritis
___ TMJ
___ Cysts
___ Bursitis
___ Plantar Fascitis
___ Tendonitis
___ Torticollis
___ Whiplash Syndrome
___ Carpal Tunnel Syndrome
___ Sciatica
___ Thoracic Outlet Syndrome
___ Headache
___ Leg Pain
___ Arm Pain/Shoulder Pain
___ Low Back Pain
___ Mid Back Pain
___ Hip Pain
___ Other _____

RESPIRATORY
___ Pneumonia
___ Sinusitis
___ Asthma
___ Trouble Breathing
___ Dizziness
___ Other_____

CIRCULATORY
___ Anemia
___ Hemophilia
___ Hypertension
___ Low Blood Pressure
___ Raynaud's Disease
___ Varicose Veins
___ Heart Condition
___ Blood Clots/Phlebitis
___ Diabetes
___ Other _____

DIGESTIVE
___ Ulcers
___ Irritable Bowel Syndrome
___ Gallstones
___ Hepatitis
___ Crohn's Disease
___ Diarrhea
___ Gas/Bloating
___ Indigestion

SKIN
___ Fungal Infections
___ Acne
___ Impetigo
___ Dermatitis/Eczema
___ Psoriasis
___ Open Wound or Sore
___ Rashes
___ Athletes Foot
___ Other _____

NERVOUS SYSTEM
___ ALS
___ Multiple Sclerosis
___ Parkinson's Disease
___ Bell's Palsy
___ Neuritis
___ Spinal Cord Injury
___ Stroke
___ Trigeminal Neuralgia
___ Seizure Disorders
___Numbness/Tingling/Twitching
___ Other _____

OTHER
___ Insomnia
___ Anxiety/Panic Attacks
___ PMS
___ Grief Process
___ Cancer
___ Substance Abuse
___ Pregnancy
___ Chronic Fatigue
___ HIV/AIDS
___ Lupus
___ Kidney Disease
___ Bladder Infection
___ Postoperative Situation
___ Edema
___ Other _____

~Cancellation Policy~ I understand that unanticipated events happen occasionally in everyone's life. In my desire to be effective & fair to all clients, the following policies are honored: *Less than 24 hours notice: 50% appointment fee. *No call/No show: 100% appointment fee.

Signature: _____Date:_____