ProCare Physical Therapy

19033 E. Plaza Drive
Parker, CO 80134
(303) 805-4497

Confidential Massage Patient Information (pg. 1 of 2)

Name _____ Date of Birth _____

Phone #: Home _____ Cell _____ Work _____

Address _____ City/Zip Code _____

Occupation _____ Employer Name & Address _____

Emergency Contact Name and Phone #: _____

How did you hear about us?
Referred By: _____ Online _____ Drive By ☐ Other _____

Have you ever experienced a professional massage? _____ If so, when? _____

General Medical Information:
Did you have a motor vehicle accident, a work comp injury, or chronic pain due to other circumstances? Please explain:

Describe any health condition(s) treated by a physician in the last year:

Please circle any of the following conditions that you currently have **OR** have had:

(circle appropriate one)

☐ Atherosclerosis	☐ Asthma	☐ Cancer	☐ Blood Pressure(High/Low)
☐ Blurred Vision	☐ Bowel/Bladder	☐ Viral Infection	☐ Blood Clots/Thrombosis
☐ Chronic Pain	☐ Currently Pregnant	☐ Diabetes	☐ Dizziness/Nausea
☐ Fibromyalgia	☐ Frequent Headaches	☐ Heart Problems	☐ Infectious Disease
☐ Inflammation	☐ Kidney Infection	☐ Lupus	☐ Multiple Sclerosis
☐ Osteoporosis	☐ Peritonitis	☐ Repetitive Use Injury	☐ Respiratory Problems
☐ Skin Infection	☐ Stroke	☐ Skin Sensitivity	☐ Rheumatiod Arthritis
☐ TMJ	☐ Surgery (last 6 mos.)	☐ Traumatic Head Injury	☐ Broken Bones (last 3 yrs.)

Explanations:

ProCare Physical Therapy

Confidential Massage Patient Information (pg. 2 of 2)

Do you generally have tension or soreness in a specific area? If so where?

Are you very sensitive to touch or pressure in those, or any other areas?

Do you have numbness or stabbing pains anywhere? If so, where?

Do you have any other medical conditions that ProCare Physical Therapy should be aware of?

Please **read** and **understand** the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage may be contraindicated. A written referral from your primary care physician may be required prior to service being provided.

I understand that the massage (s) I receive are provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during any session, I will immediately inform the practitioner so the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, specialist for any mental or physical ailment that I am aware of. I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of any session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of any session, and I will be liable for payment of the full scheduled appointment.

Patient Signature _____ Date _____

Practitioner Signature _____ Date _____

Consent to treatment of a minor: By my signature below, I hereby authorize _____ to administer massage therapy to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____