PATIENT INFORMATION

RAVE MASSAGE

Please print clearly:

Name _____ Occupation _____

Address_____ City_____ Postal Code_____

Date of Birth (MM/DD/YYYY) ____ /____/_____ Email_____

Phone (Home) _____ (Cell)_____

Have you ever had a massage? ❍ YES ❍ NO How did you hear about the clinic? _____

What are your treatment expectations (i.e. relief of headache pain, rehabilitation, etc)?

HEALTH HISTORY Please check any that apply to you:

GENERAL

❍ Headaches
Type_____
❍ Vision Problems
❍ Sinus
❍ Allergies
❍ Chronic Pain
❍ Chronic Fatigue
❍ Dizziness
❍ Premenstrual Syndrome PMS
❍ Menopause
❍ Pregnancy # of Weeks _____

SKIN

❍ Sensitive Skin
❍ Rashes or Sores
❍ Warts
❍ Varicose Veins
Diagnosed? ❍ YES ❍ NO
❍ Eczema
❍ Psoriasis

CARDIOVASCULAR

❍ High Blood Pressure
Medicated? ❍ YES ❍ NO
❍ Low Blood Pressure
Medicated? ❍ YES ❍ NO
❍ Poor Circulation
❍ Heart Disease
❍ Phlebitis

RESPIRATORY

❍ Chronic Cough
❍ Shortness of Breath
❍ Smoker
❍ Asthma
❍ Chronic Colds

DIGESTIVE/URO-GENITAL

❍ Poor Appetite
❍ Constipation
❍ Kidney/Bladder
❍ Digestive Problems
❍ Hernia

MUSCLES AND JOINTS

❍ Stiffness
❍ Swelling
❍ Limited Movement
❍ Back Pain
❍ Shoulder Pain
❍ Neck Pain
❍ Pain in Limbs
❍ Pins and Needles
❍ Rheumatoid Arthritis
Date Diagnosed _____
❍ Osteoarthritis
Date Diagnosed _____

OTHERS

❍ Hepatitis
❍ Diabetes
Medicated? ❍ YES ❍ NO
❍ Epilepsy
Medicated? ❍ YES ❍ NO
❍ Immune Disorder
❍ Cancer
❍ Depression/Grief

Please list any medical condition/medication that your Therapist should be advised of:

CONSENT FOR TREATMENT

I hereby grant permission to Rave Massage to perform such Massage Therapy procedures professionally deemed necessary or advisable for my diagnosis and treatment. I understand that I am responsible for updating my personal information should my condition change.

Date _____ Signature _____