Connective Touch Therapeutic Massage
1712 Clubhouse Road, Suite 102 Reston, VA 20190
703-568-2010

Name: ____ Today's Date: ___________________

Address: ____

City: _____________________________________ State: ________ Zip Code: _______________

Telephone: Day ____________ Evening ___________ Email ____________________________

Birth Date: ________ Occupation: ____________________ Referred By: __________________

Emergency Contact/relationship: ___________________________________ Phone: __________

Have you had professional massage/bodywork previously? ___________ If so, how often did you receive massage and when was your last session? ____

What would like to accomplish in today's session? ____

Are you currently under the care of a physician? _____ If so, please explain: ___________________________

____

Please list medications/supplements you are taking and the side effects, if any that you experience: ______________

____

Describe your medical/surgical history including dates of occurrence: ______________________________

____

Describe any acute or chronic injuries: ____

Please list any known allergies: ____

Describe your current exercise habits: ____

Do you currently have a cold, fever, infection or any skin irritation? ______________________________

____

Please describe any other conditions or situations effecting your overall well being: ____________________

____

Please circle any of the following conditions you have experienced in the past year

Systemic Infections
Mononucleosis
Hepatitis
Viral (Chicken Pox, measles)
Other_______________

Musculoskeletal
Fibromyalgia
Cramping/spasms
Sprains/Strains
Scoliosis
Herniated Disc
Fractures
Spinal Injury
Other_______________

Cardiovascular
Heart Disease
High Blood Pressure
Varicose Veins
Anemia
Stroke/Blood Clots
Phlebitis
Other_______________

Skin
Skin Cancer
Fungal Infections
Eczema
Psoriasis
Painful scars/bruises
Other_______________

Nervous
Multiple Sclerosis
Neuropathy/Neuralgia
Seizures
Headaches/migraines
Other_______________

Respiratory
Asthma
Emphysema
Hayfever/allergies
Other________________

Endocrine
Diabetes
Hypoglycemia
Hyper/hypothyroidism
Other_______________

Reproductive
Males: Prostate
Other________________
Females: PMS
Endometriosis/fibroids
Breast cysts
Other_______________

Digestive
Constipation
Diarrhea
Colitis
Other________________

Immune
Lymphoma
Lymphedema
Other________________

Emotional
Mood Swings
Sleep Disorders
Other________________

Other: ______________
____
____
____

Females: Are you currently pregnant? ____ If so, when are you due? ____

Have you had any complications with your pregnancy? Please describe____

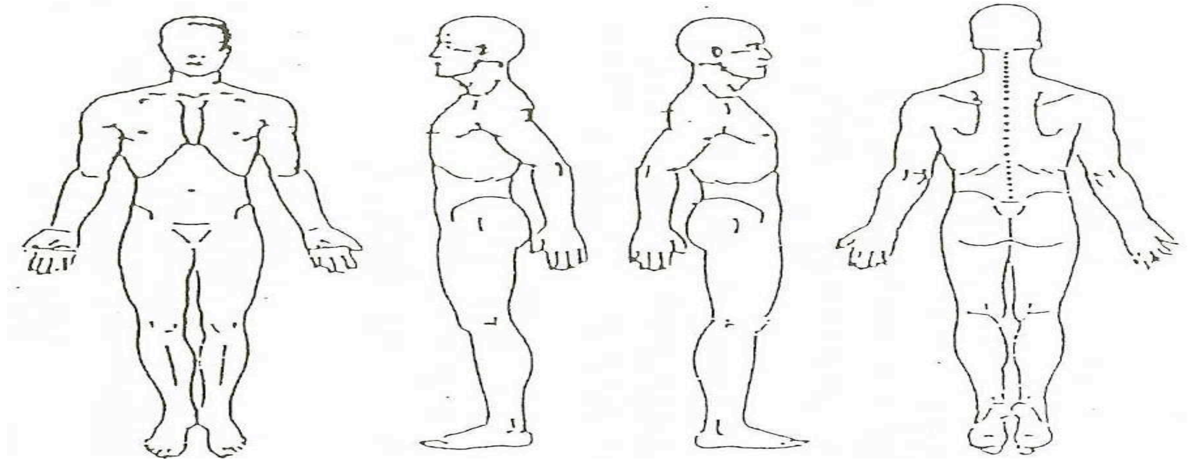
____

Have you had an amniocentesis? _______ If so, when? ________ Most recent ultrasound_______________________

Have you had any bleeding, cramping or noticed any change in the baby's movement in the past 24 hours? Explain

____

Please mark on the figures the areas where you have pain, tension, discomfort.



Disclaimer: Please note that a massage therapist does not diagnose or medically treat conditions. Please consult your physician first with any medical conditions you may be currently experiencing.

Cancellation Policy: Please provide **24 hour** notice for any appointment which you are unable to attend. A minimum of $50 will be charged for non-emergency cancellations with less than 24 hours notice. The full price of the session will be charged for a **NO CALL/NO SHOW.**

I understand the above statement and explanation of the Cancellation Policy:

Signature: ____ Date: ________________________________