Robert Covington Massage Therapy

Name_____Phone_____ _Cell_____

Address_____City_____State_____Zip_____

Occupation_____Date of Birth_____

Major Complaint_____

Minor Complaint_____

Any area you would prefer NOT to be worked (please circle):

Head Face Chest/Pecs Arms StomachBack Legs Feet

Do you have or ever had any of the following conditions (circle any that apply)?

High/Low Blood Pressure	Skin Disorders	Headaches	Scoliosis
Low Back Problems	Heart Condition	Nerve Damage	Cancer
Fever (within last 24 hrs)	Broken Bones (identify)	Neck/Whiplash	Diabetes
Varicose Veins	Tumors/Cysts	Abuse Issues	Arthritis
Blood Clots (location)	Head Injury	Fibromyalgia	TMJ

Any condition not mentioned above that massage may effect:_____

Have you had surgery? Type_____

Have you had any accidents? Type/Date_____

Are you presently under the care of a physician? Name_____

List any other therapy you are recieving:_____

List medications you take regularly:_____

List any medications used in the last year:_____

How long since your last dose today:_____

Do you drink (circle all that apply):

Coffee Soda Tea Amount per day_____ Weekly_____ (cups/glasses/cans)

Alcohol Amount per day_____ Weekly_____

Water Amount per day_____ Weekly_____

Do you exercise regularly?_____ What kind and how frequently?_____

Release & Consent: The above information is accurate to the best of my knowledge. I understand that the massage therapist, while trained in Massage Therapy, is not trained to diagnose or treat any form of illness, disease, or injury and that I will be receiving massage therapy as a form of adjunctive health care only and that this Therapy is not intended to replace appropriate medical care. I do forever release the practitioners and their insurers, from all liability of any nature whatsoever, whether past, present, or future for injury or damage which may occur as a result of my receiving Massage Therapy. I agree to hold harmless and defend the practitioner of and all actions, claims, or other legal or administrative action that has arisen or may arise from my participation in this therapy.

Signature_____ Date_____