**TOUCH MATTERS THERAPEUTIC MASSAGE & BODYWORK**
**HEALTH ASSESSMENT AND INFORMED CONSENT**
**Rosalie Jacobi Hutchens, BFA, LMBT (NC License #5792) Phone: (252) 717-0012**

Thank you for your visit. I sincerely hope, based upon my experience and certified training, that the massage you receive will help you on your way to a more relaxed, healthy, and balanced way of living. Please take a few moments to fill out this form. It will enable me to give you the best therapy suited to your needs, goals, and expectations. If you have any existing medical conditions, please check with your healthcare provider prior to your massage. I encourage you to do so; a relaxed mind is the beginning of a wonderful massage!

**Name** ____________________ **Date of Birth** ____________________

**Address/CSZ** ____________________ **Occupation** ____________________

**Phone (1)** ____________ **(2)** ____________ **Email** ____________________

**Primary reason for appointment** ____________________

**Areas of pain/tension/stiffness** ____________________

**Who referred you?** ____________________

Have you had a professional massage before? **YES** **NO** If YES, how often and how recently? ____________________

____________________

**Medical History: (Please check all that apply)**

_______High blood pressure
_______Heart disease
_______Blood clots
_______Varicose veins
_______Phlebitis
_______Fluid retention
_______Epilepsy
_______Headaches
_______Cancer/malignancy
_______Diabetes
_______Fractures
_______PMS/painful menstruation
_______Easy bruising
_______Skin rash
_______Abscess or open sore
_______Skin sensitivity
_______Allergies
_______Herpes I or II
_______HIV positive
_______Other infectious disease
_______Currently pregnant
_______Psych. disorder Specify: ____________
_______Osteoporosis
_______Osteoarthritis
_______Rheumatoid arthritis
_______Fibromyalgia
_______Lymph node removal
_______Chronic Fatigue Syndrome
_______Herniated disc(s)
_______Other spinal problems
_______Other (describe) ____________
____________________

Do you wear contacts?: **YES** **NO** dentures?: **YES** **NO** hearing aid?: **YES** **NO**

What medications, including supplements and vitamins, do you take? Please list: ____________________

____________________

____________________

Recent surgery or acute injuries (explain and give dates): ____________________

Old injuries (explain and give dates): ____________________

Implants of any kind? (such as pins or knee/hip replacements): **YES** **NO** If yes, where?: ____________________

List any other physical or health difficulties: ____________________

Do you have any difficulty lying on your back, front, or turning over on the table?: **YES** **NO**

Name of Healthcare Provider (physician, chiropractor, other) ____________________ Phone ____________

**This information will be treated confidentially. In order to maximize the effectiveness and safety of each session, please give your feedback during and at the end of the sessions. This will help in tailoring each session to serve in the best possible way.**

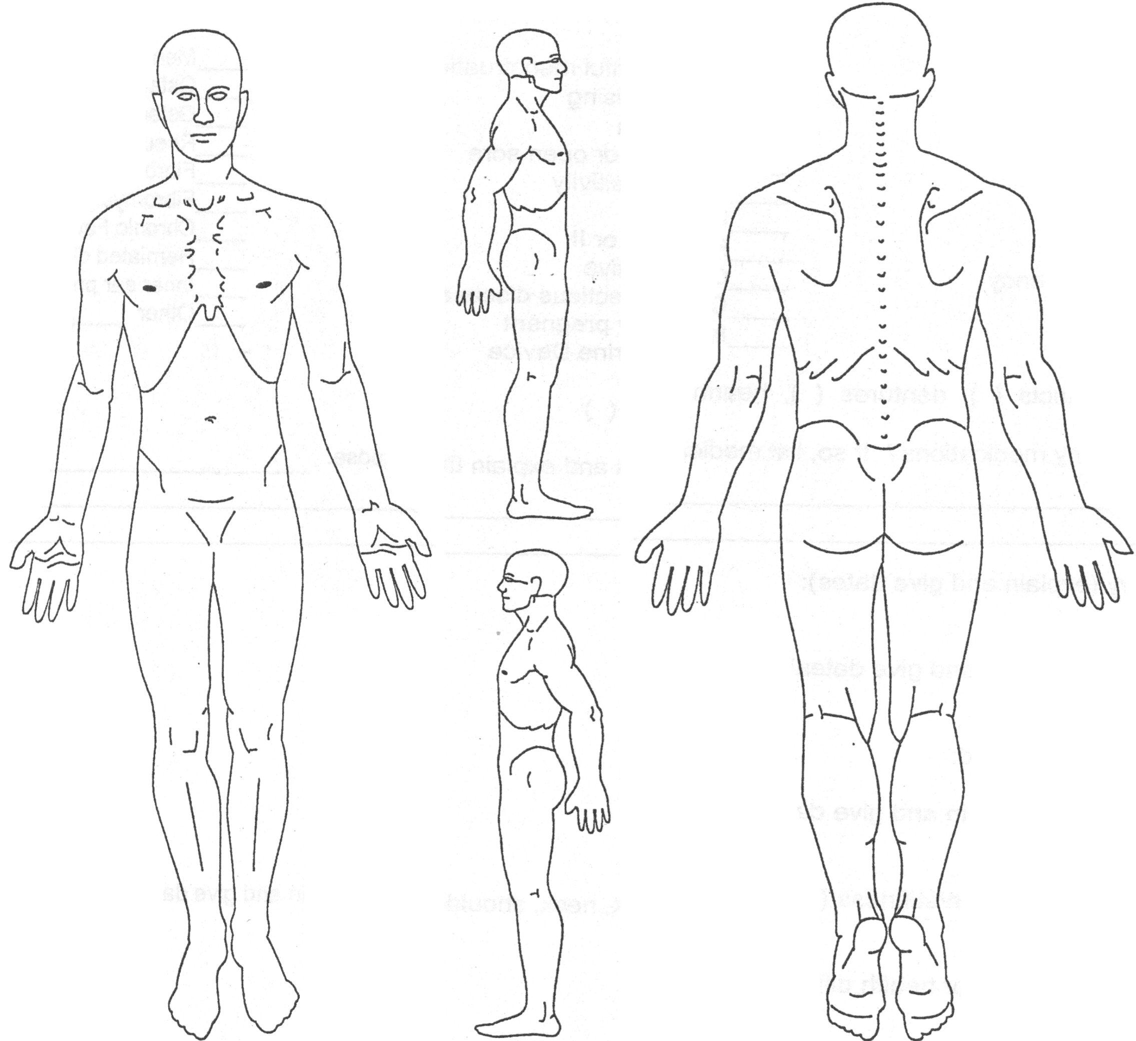
**PLEASE READ AND SIGN:**

I understand that therapeutic massage is for the purpose of stress reduction, relief from muscular discomfort, and wellness care. Massage therapists do not diagnose illness, disease, or any other disorders, and do not prescribe medical treatment or medication or perform spinal manipulation. Massage therapy is not a substitute for medical examination or diagnosis. I have, to the best of my knowledge, stated all my known medical conditions and take it upon myself to keep my massage therapist updated about my health.

Signature ____________________ Date ____________________

Please draw the location of your pain, discomfort, or tension on the images below. Use the symbols shown to represent the type(s) of pain, if any. (Feel free to write your own notes and descriptions in the margins.)

**D** = Dull  **S** = Stabbing/Cutting
**B** = Burning  **T** = Tingling (Pins & Needles)
**N** = Numb  **C** = Cramping



**Pain Rating Scale**

Beside each area of pain/discomfort/stiffness, etc. that you have indicated on the drawings, please rate the discomfort with a number from 1 – 10. This is a way to measure your discomfort. Use the list below:

- 1 to 3 = Minor (does not interfere with most activities)
- 4 to 7 = Moderate pain (interferes with activities; unable to completely adapt)
- 8 to 9 = Severe pain (unable to engage in normal activities; can no longer think clearly)
- 10 = Unimaginable / Unbearable (so intense that you will shortly go unconscious)

**What do you do to relieve tension/stress?:**

**On back of this page, feel free to tell me anything else that you think would help me give you a session perfectly tailored to your needs!**