DEEP TISSUE SPOKANE ***RENNAE SCHMIDT, LICENSED MASSAGE THERAPIST***

112 N UNIVERSITY RD., #B106, SPOKANE VALLEY, WA 99206. ***OFFICE: 509-280-6720***
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CLIENT INFORMATION AND HEALTH HISTORY

PERSONAL INFORMATION

FIRST NAME_____LAST_____
ADDRESS_____STATE_____ZIP_____
PHONE(H) _____ (C)_____DATE OF BIRTH*_____
EMAIL ADDRESS_____
EMPLOYEROCCUPATION_____

**For birthday specials only*

IS IT APPROPRIATE TO CONTACT YOU REGARDING YOUR MASSAGE AT THE ABOVE NUMBERS? Y_____N_____IN CASE OF EMERGENCY CONTACT_____
PHONE_____RELATIONSHIP_____

MASSAGE EXPERIENCE 1st PROFESSIONAL MASSAGE? Y__N__ IF NO, HOW FREQUENTLY DO YOU GET A MASSAGE?_____WHAT DO YOU HOPE TO ACCOMPLISH FROM TODAY'S MASSAGE?_____
ARE YOU AWARE OF ANY TENSION IN YOUR BODY? Y__N__ IF YES, LOCATION(S)_____
_____

MEDICAL HISTORY DESCRIBE ANY SURGERIES, HOSPITALIZATIONS, ACCIDENTS OR INJURIES YOU HAD: LESS THAN 5 YEARS AGO:_____
_____

WHAT KIND OF CARE DID YOU RECEIVE FOR YOUR ACCIDENTS OR INJURIES?_____
_____

DO YOU FEEL YOU HAVE RECOVERED FROM THESE EVENTS? Y__N__ IF NO, PLEASE EXPLAIN:_____
_____

MEDICAL PROVIDER INFORMATION ARE YOU CURRENTLY/OR HAVE BEEN UNDER THE CARE OF A **PHYSICIAN**? Y__N__ IF SO, WHEN? _____ WHO_____
PLEASE LIST REASONS_____
_____ARE YOU CURRENTLY/OR HAVE BEEN UNDER THE CARE OF A **CHIROPRACTOR**? Y__N__IF SO, WHEN?_____
WHO?_____ PLEASE LIST REASON(S):_____
_____

MEDICATIONS

PLEASE LIST ANY MEDICATION (VITAMINS, HERBS OR PHARMACEUTICALS) TAKEN NOW OR AT REGULAR INTERVALS
(INCLUDE INFORMATION OF WHAT MEDICATION IS USED TO TREAT):_____

_____

_____

DO/DID YOU SMOKE? Y__N__HOW MUCH DAILY?_____

CURRENT MEDICAL COMPLAINTS/CONDITIONS DO YOU HAVE ANY CHRONIC, ONGOING PAIN THAT YOU DEAL WITH ON A REGULAR BASIS?_____

_____

DESCRIBE WHAT ACTIVITIES CAUSE THIS PAIN AND/OR MAKE IT WORSE?_____

_____

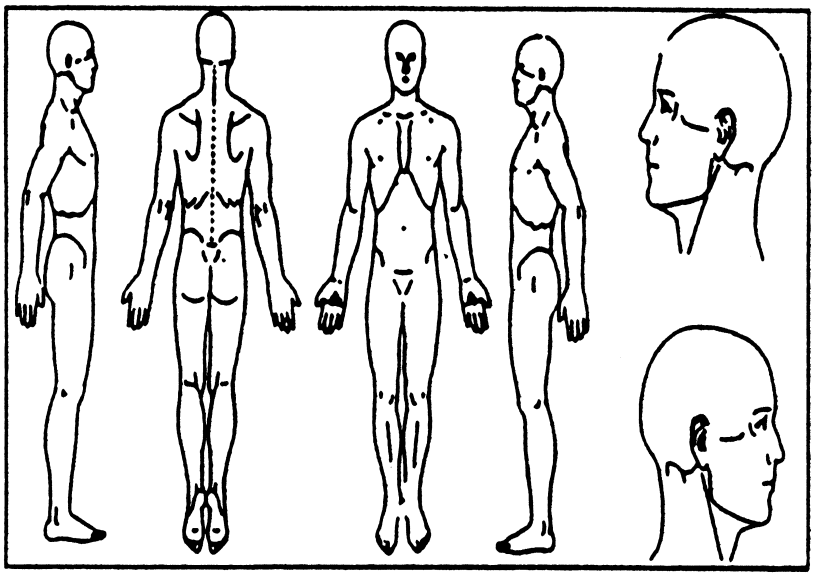
ARE YOU RECEIVING ANY OTHER TYPE OF MEDICAL TREATMENT? Y__N__ EXPLAIN:_____

_____

ARE THERE ANY OTHER HEALTH CONCERNS YOU WISH TO DISCUSS TODAY? Y__N__ IF YES, PLEASE DESCRIBE_____

_____

PLEASE SHADE IN WHERE YOU EXPERIENCE PAIN ON THE DRAWING BELOW



PLEASE ANNOTATE ANY OF THE FOLLOWING CONDITIONS THAT CURRENTLY AFFECT YOU OR THAT YOU HAVE EXPERIENCED IN THE LAST 5 YEARS:

Are you having any MUSCULOSKELETAL (muscle/skeletal) conditions/diagnosis'/problems?_____

_____

Are you having any RESPIRATORY conditions/diagnosis'/problems?_____

_____

Are you having any CIRCULATORY conditions/diagnosis'/problems?_____

_____

Are you having any DIGESTIVE conditions/diagnosis'/problems?_____

_____

Are you having any SKIN conditions/diagnosis'/problems?_____

_____

Are you having any NERVOUS SYSTEM conditions/diagnosis'/problems?_____

_____

Are you having any OTHER conditions/diagnosis'/problems?_____

_____

THE ABOVE INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT MASSAGE THERAPISTS DO NOT DIAGNOSE DISEASE, PRESCRIBE MEDICATIONS OR MANIPULATE BONES. I FURTHER UNDERSTAND THAT MASSAGE THERAPY IS NOT A SUBSTITUTE FOR MEDICAL ATTENTION OR EXAMINATION. I TAKE RESPONSIBILITY FOR ALERTING MY PRACTITIONER TO ANY PHYSICAL, MENTAL OR EMOTIONAL CHANGES THAT OCCUR WITH MY HEALTH.

I ALSO UNDERSTAND THAT CANCELLED OR MISSED APPOINTMENTS WITHOUT 24 HOURS NOTICE WILL RESULT IN $65.00 CHARGE TOWARDS MY ACCOUNT. (MEDICAL or FAMILY EMERGENCIES or ILLNESSES EXCLUDED)

SIGNATURE _____ **DATE** _____