New York Orthopedic Massage (NYOM) **231 W 21st ST Lower Level – New York, NY 10011**

CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

Name: ____
Last Name First Name Initial

Address: ____

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Home Phone #: ______________________________

Work Phone #: ______________________________

Cell Phone #: ______________________________

E-mail Address: ______________________________

Sex: ❑ M ❑ F Age:________ Birth date:________________

❑ Single ❑ Married ❑ Divorced ❑ Widowed

Occupation: ______________________________

Employer: ______________________________

Employer Address: ______________________________

Employer Phone #: ______________________________

IN CASE OF AN EMERGENCY, CONTACT

Name:____________________ Relation: ________________

Phone #:______________________________

PRIMARY PHYSICIAN: ______________________________

How did you hear about us? ______________________________

Is this your first professional massage? ❑ Yes ❑ No 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 holding spots in your body?______________ If yes, location(s) ______________________________

Describe any surgeries, hospitalizations, accidents or injuries you have had:

Less than 5 years ago: ____

More than 5 years ago: ____

What kind of care did you receive for your accidents or injuries? ____

Do you feel that you have recovered from these events?_______________ Please explain: ______________________________

Do you have any chronic, ongoing pain that you deal with on a regular basis? ______________________________

Please explain ____

Describe what activities cause this pain and/or make it worse? ____

Are you receiving any other type of medical treatment?_______________ Please explain: ______________________________

Please list any medication (vitamins, herbs, or pharmaceutical) taken now or at regular intervals (include explanation of what medication is used to treat): ____

____

Are you currently under the care of a physician?________________ Whom? ______________________________

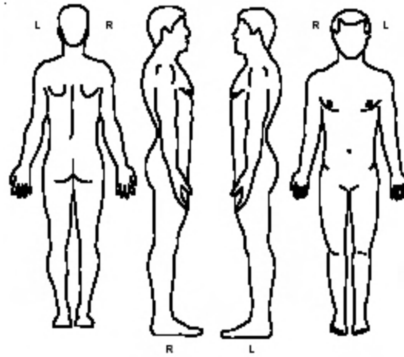
Please list reason(s): ____

Are there any other health concerns you wish to discuss today:______________ If yes, please describe: ______________________

Are you currently experiencing any of the following conditions?

___Flu or Cold____Inflammation____Fever_______Infection______Contagious Disease

PLEASE INDICATE WHERE YOU EXPERIENCE PAIN ON THE DRAWING BELOW:



Please check any of the following conditions below that currently affect you or that you have experienced in the last 5 years. (place "X" in boxes that apply)

MUSCULOSKELETAL
- ❑ Fibromyalgia
- ❑ Spasms/Cramps
- ❑ Sprains/Strains
- ❑ Osteoporosis
- ❑ Postural Deviations
- ❑ Gout
- ❑ Osteoarthritis/Rheumatoid Arthritis
- ❑ TMJ
- ❑ Cysts
- ❑ Bursitis
- ❑ Kidney, Bladder (GU)
- ❑ Plantar Fascitis
- ❑ Tendonitis
- ❑ Torticollis
- ❑ Whiplash Syndrome
- ❑ Carpal Tunnel Syndrome
- ❑ Sciatica
- ❑ Thoracic Outlet Syndrome
- ❑ Headache
- ❑ Leg Pain
- ❑ Arm Pain/Shoulder Pain
- ❑ Lower Back Pain
- ❑ Mid Back Pain
- ❑ Hip Pain
- ❑ Other ___________________

RESPIRATORY
- ❑ Pneumonia
- ❑ Sinusitis
- ❑ Asthma
- ❑ Trouble Breathing
- ❑ Dizziness
- ❑ Other _________________

CIRCULATORY
- ❑ Anemia
- ❑ Hemophilia
- ❑ Low Blood Pressure
- ❑ Raynaud's Disease
- ❑ Varicose Veins
- ❑ Heart Condition
- ❑ Blood Clots/Phlebitis
- ❑ Diabetes
- ❑ Other _______________

DIGESTIVE
- ❑ Ulcers
- ❑ Irritable Bowel Syndrome
- ❑ Colitis
- ❑ Gallstones
- ❑ Hepatitis
- ❑ Crohn's Disease
- ❑ Diarrhea
- ❑ Gas/Bloating
- ❑ Indigestion
- ❑ Other __________________

SKIN
- ❑ Fungal Infections
- ❑ Acne
- ❑ Impetigo
- ❑ Dermatitis/Eczema
- ❑ Psoriasis
- ❑ Open Wound or Sore
- ❑ Rashes
- ❑ Warts/Moles
- ❑ Athlete's Foot
- ❑ Other __________________

NERVOUS SYSTEM
- ❑ ALS
- ❑ Multiple Sclerosis
- ❑ Parkinson's Disease
- ❑ Bell's Palsy
- ❑ Neuritis
- ❑ Spinal Cord Injury
- ❑ Stroke
- ❑ Trigeminal Neuralgia
- ❑ Seizure Disorders
- ❑ Numbness/Tingling/Twitching
- ❑ Other _____________________

OTHER
- ❑ Insomnia
- ❑ Anxiety/Panic Attacks
- ❑ PMS
- ❑ Grief Process
- ❑ Cancer
- ❑ Substance Abuse
- ❑ Pregnancy
- ❑ Chronic Fatigue
- ❑ HIV / AIDS
- ❑ Lupus
- ❑ Kidney Disease
- ❑ Bladder Infection
- ❑ Postoperative Situation
- ❑ Edema
- ❑ Other _____________________

AUTHORIZATION FOR TREATMENT

The above information is accurate and true to the best of my knowledge. I understand that Massage Therapist do not diagnose disease, prescribe medication 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 appointment without 24 hour notice (medical emergencies excluded) may be charged in full for the price of the missed session.

Patient's Signature:____Date:______________________________

E-mail