PRO MEDICAL PHYSICAL THERAPY

Medical Massage Medical History

All information is confidential

____
Name (Last)   (First)   (MI)   Date of Birth

Please take a moment to carefully read the following list of conditions and questions below and check any that have affected your health either recently or in the past. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

[ ] Migraines or frequent headaches
[ ] Muscle Pain/Cramps
[ ] Cardiac or Circulatory Problems
[ ] Back Pain
[ ] Cellulite
[ ] Fluid Retention
[ ] Weight Gain
[ ] Dry Skin
[ ] Difficulty relaxing
[ ] Lethargy
[ ] Insomnia
[ ] Varicose Veins
[ ] Blood Clots
[ ] Osteoporosis
[ ] Epilepsy or Seizures

[ ] Skin Rashes
[ ] High or Low Blood Pressure
[ ] Arthritis or Joint Swelling
[ ] Diabetes
[ ] HIV Positive
[ ] Fibromyalgia
[ ] Heart Problems____
[ ] Pregnant Trimester_______________________________________
[ ] Contagious Condition_____________________________________
[ ] Taking Medications______________________________________
[ ] Cancer ____
[ ] Surgeries ____
[ ] Accidents ____
[ ] Any other health concerns ____

Are you currently seeing healthcare professional? [ ] No [ ] Yes If yes, please list provider's name(s) and reason/treatment:

____

Do you have any allergies to, please check all that apply:

[ ] Medication
[ ] Food (nuts, dairy, etc.)
[ ] Reactions to Skin-Care Products
[ ] Environmental allergens (dust, pollen, fragrances)
[ ] Other _____________________

LIFESTYLE

Do you frequently suffer from stress? [ ] No [ ] Yes (explain) ________________________________

Rate your level of stress on a scale of 1-10 (10 being the highest) ___________

Does Stress affect any of the following? [ ] Skin [ ] Digestion [ ] Breathing [ ] Sleep [ ] Health [ ] Muscle Tension

What do you do to relieve stress? ____

What type and how frequently do you exercise? ____

What is your current homecare regime? ____

Do you have numbness or stabbing pains anywhere? [ ] No [ ] Yes (explain) ____

Are you sensitive to touch or pressure in any area? [ ] No [ ] Yes (explain) ____

Have you had any broken bones in the past two years? [ ] No [ ] Yes (explain) ____

Have you been in an accident or suffered any injuries in the past two years? [ ] No [ ] Yes (explain) ___________________________

Do you bruise easily? [ ] No [ ] Yes

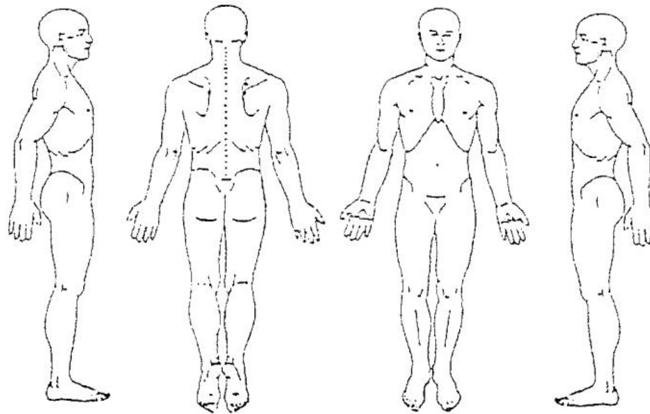
Last time you received a massage________________ Type of Massage (i.e.: Swedish, Deep Tissue, Shiatsu) _____________________

Primary Reason for Massage (maintain health, relaxation , reduce stress, manage pain, relieve discomfort): _________________________

What kind of pressure do you prefer? [ ] Light [ ] Medium [ ] Firm [ ] Combination

Does anything limit you from care? [ ] No [ ] Yes (explain) ____

On the figures, please indicate with an X, if any, the area(s) in which you are feeling discomfort, pain, soreness, or tension:



The above information is true and accurate to the best of my knowledge. I am aware of and will inform my practitioner(s) of any changes in my health. I take full responsibility for alerting my practitioner to any physical condition that would affect this work.

(Initials: _____)

Waiver. I understand and acknowledge there are risks involved with the treatment of the Massage procedure. I have had the opportunity to ask questions regarding these risks and other possible complications. I understand any false or misleading information I have given may lead to undesired results and complications and hereby waive PRO's liability if such results or complications occur. I further understand my failure to follow post care instructions may also lead to undesired results, complications or effects and hereby waive PRO's liability if such results or complications occur. I understand that the massage therapist does not prescribe medical treatment or pharmaceuticals, nor does he/she perform any spinal adjustments. Massage therapy is not a substitute for medical examinations and diagnosis. It is recommended that I see a physician for any physical or mental ailment that I might have. I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental conditions. Any sexual misconduct exhibited by the client will result in immediate termination of the session, and the client will be liable for payment of the scheduled appointment. If for any reason I am uncomfortable, I may ask the therapist to cease the massage and the therapist will end the session. If I cancel, reschedule, or skip an appointment without 24 hours notice, I agree to forfeit the full session fee.

In consideration for PRO performing this procedure, I agree I will assume the risk and full responsibility for any and all injuries, losses, or damages, which might occur to me while I am undergoing this procedure or side effects I may experience after the procedure is performed. To the maximum extent allowed by law, I agree to waive and release any and all present and future claims, suits or related causes of action against Professional Recreation Organization, Inc., d/b/a PRO Sports Club, its owners, officers, employees, or agents for negligence, injury, loss, death, costs or other injuries or damages to me as a result of this procedure. I agree this waiver and release shall bind the members of my family and any spouse or domestic partner, if I am alive, as well as my estate, family, heirs, administrators, personal representatives or assigns if I am deceased, and shall be deemed as a "Release, Waiver, Discharge and Covenant" not to sue PRO Sports Club.

MAXIMUM LIABILITY. PRO SPORTS CLUB'S MAXIMUM AGGREGATE LIABILITY TO PATIENT RELATED TO OR IN CONNECTION WITH THE PROCEDURE PERFORMED BY PRO SPORTS CLUB, ITS EMPLOYEES, OR AGENTS WILL BE LIMITED TO THE TOTAL AMOUNT PAID TO PRO SPORTS CLUB BY PATIENT FOR THE PROCEDURE DESCRIBED IN THIS AUTHORIZATION AND CONSENT.

____________________________________ ____________________________________ **Date _____ / _____ / ______**

Client Signature **Therapist Signature**