James Madison University
Massage Therapy Personal Data and Health Screen

Name:_____ Date:_____

Address:_____ Age:_____

Phone:_____ Email:_____

Date of Birth:_____ Referred by:_____

Please check one: ____Student____Faculty/Staff____Other Department/Graduation date_____

Interest(s):_____

What is your previous experience with professional massage?_____

What is your goal(s) for today's session?_____

Is there any area where you seem to hold a lot of tension or an area on which therapist should focus?_____

Is there any area you would prefer left out of the massage?_____

Lifestyle: Please give brief example of these aspects:
Nutrition:_____
Exercise:_____
Tobacco:_____ Alcohol:_____ Drugs (non-med.):_____
Posture for the most of the day:_____
Sleep:_____ Bowels:_____ Caffeine:_____
Recreation:_____

Do you wear contacts? Y N Dentures? Y N Hearing Aid(s)? Y N

Are there specific aspects of your life that are particularly stressful (job, posture, habits, diet, family, etc)?
Please explain:_____
_____

Have you had a fever in the last 24 hours? Y N

Medical History: (Give Dates)

____Hypertension	____PMS/Painful Menstruation	____Mental Illness
____Heart Disease	____Easy Bruising	____Osteoporosis
____Arteriosclerosis	____Skin Rash	____Osteoarthritis
____Varicose Veins	____Abscess or Open Sore	____Rheumatoid Arthritis
____Phlebitis	____Skin Sensitivity	____Fibrosistis
____Fluid Retention	____Allergies	____Fibromyalgia
____Epilepsy	____Herpes I or II	____Chronic Fatigue Syndrome

____Headaches	____HIV Positive	____Herniated Disk
____Cancer/Malignancy	____Other Infectious Diseases	____Inner Ear Problems
____Diabetes	____Pregnant	____Other
____Fractures	____Intra Uterine Device	

Are you taking any kind of medications? If so, what and what for?_____
_____

____Surgery/Fractures (Please explain and give dates):

____Implants of any kind (Please explain and give dates):

____Prior Injuries (Please explain and give dates):

____Musculoskeletal pain/stiffness (low back, neck, shoulders, etc) (Please explain and give dates):

Any other physical or health challenges?

Any difficulty lying on your back, front, or turning?

To better develop a massage session that meets your individual needs, it will be helpful to know if you have: (Please check all that apply):
____Any counseling history
____Any history of abuse (Recent or past, verbal, physical, sexual, emotional)
____Are you under the care of a physician or other medical practitioner now?

Do we have your permission to contact your physician should the need arise? Y N
Name of physician:_____ Phone:_____

This information will be treated confidentially. In order to maximize the effectiveness and safety of the massage session, please give us your feedback during and at the time of the session. The James Madison University Massage Therapy Program is a professional service to offer relief from muscular tension. At no point should you feel uncomfortable. Please immediately report discomfort of any kind, whether pertaining to the massage itself, room temperature, music volume, or other distractions.

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I have read the above information, and I understand this work does not constitute as medical treatment. It is a form of health and wellness maintenance utilizing the techniques of traditional Swedish and sports massage. I take the responsibility for alerting my practitioner to any physical or emotional conditions that would affect this work.

_____ _____
Signature of Participant Date

_____
Signature of Parent/Guardian if participant is under 18 years of age and not a JMU student