Debbie VanHeel LMP

Patient Information

Name:____
Address:____
City: ________________________________ State: ___________ Zip:_______________
Home Phone: ____________ Cell Phone: ______________ Work Phone:______________
E-Mail: ________________________________ Date of Birth:__________________
Occupation:____
Emergency Contact: ________________________________ Phone: _________________________

Have you ever had Massage Therapy before? Yes No
Are you currently under a Doctor's, Chiropractor's or Physical Therapist's care? Yes No
If **YES**, for what condition? ____
Please list any medications you are taking: _______________________________________
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Please mark with an (X) all conditions that apply. Mark (P) for past conditions and indicate how many years ago.

tension headaches whiplash congestive heart failure
migraines osteoarthritis rheumatoid arthritis
varicose veins cancer circulatory problems
stroke disc problems spinal fusions
osteoporosis recent surgery infectious disease
diabetes recent injury high/low blood pressure
fibromyalgia heart attack hip/knee replacement
jaw pain/TMJ allergies to nut based oils/lotions

Please explain any conditions noted above *or if you have any other conditions not listed*.
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I have completed the above information to the best of my knowledge. I understand that massage therapy does not replace a physician's care. I understand that the therapist may refuse massage due to certain medical contraindications, unless the treating physician advises us in writing that massage will be beneficial. I understand that the therapist also reserves the right to refuse or discontinue massage due to unethical behavior or misconduct.

Signature: ____ Date:______________