Apex Massage

3410 Frankfort Avenue, Louisville, KY 40207
(502) 895-1262

Name____________________________________ Date__________ E-mail_______________
Address_______________________ City___________________ State________ Zip__________
Phone____________________ Occupation____________________ Date of Birth____________
Who referred you to this office? Name:____
Drove By___ Yellow Pages___ Website___ Mailer___ Other_______________________

Present Symptoms: What is your major complaint or condition you want to improve?
____
When did you first notice this?____
Is it progressively getting worse or better?_______________________________________
Has there been a medical diagnosis?____
List all medications you currently take____
Who is your regular health care provider?____

Check if you have had recent problems with any of the following:

- ○ Lymphedema
- ○ Fibromyalgia
- ○ Diabetes
- ○ Asthma
- ○ Heart condition
- ○ Chest pain
- ○ Shortness of breath
- ○ Sciatica
- ○ Scoliosis
- ○ Arthritis
  Where?____________
- ○ Osteoporosis
- ○ Bursitis
  Where?____________
- ○ Tendonitis
  Where?____________
- ○ Varicose veins
- ○ Blood clots
  Where?____________
- ○ Skin condition/Rash
  Where?____________
- ○ Infectious condition
  Where?____________
- ○ High blood pressure
  If yes, any medication?
  Please list____________
- ○ Sinus/Allergies
- ○ Seizures/Convulsions
- ○ Dizziness/Fainting
- ○ Numbness/Tingling
  Where?____________
- ○ Other?____________

Head:
- ○ Jaw pain/TMJ
- ○ Grind teeth
- ○ Lights bother eyes
- ○ Ringing in ears
- ○ Loss of balance or dizziness
- ○ Headaches
  Where?____________

Neck:
- ○ Stiffness
- ○ Pain with movement
- ○ Grinding/popping
- ○ Whiplash
- ○ Other?____________

Shoulders:
- ○ Pain with movement
- ○ Can't raise arm
- ○ Grinding/Popping
- ○ Dislocations
- ○ Other?____________

Arms and Hands:
- ○ Hands cold
- ○ Loss of grip strength
- ○ Shooting pains
- ○ Carpel Tunnel Syndrome
- ○ Thoracic Outlet Syndrome
- ○ Tennis Elbow
- ○ Other?____________

Upper Back:
- ○ Stiffness
- ○ Spasms/Cramps
- ○ Pain between Scapulas

Mid/Low Back:
- ○ Pain with movement
- ○ Spasms/Cramps
- ○ Other?____________

Hip, Legs, & Feet:
- ○ Spasms/Cramps
- ○ Pain in buttocks/hip
- ○ Shooting pains
- ○ Hip replacement
- ○ Knee pain
- ○ Other?____________

Abdomen:
- ○ Nausea
- ○ Gas
- ○ Constipation
- ○ Irritable Bowel Syndrome
- ○ Tenderness
- ○ Other?____________

Females:
- ○ Pregnant
  # of months________
- ○ Menstrual pain
- ○ Menopause
- ○ Other?____________

Massage Therapy Informed Consent

I, (please print name) ______________________________, understand that massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, and improve circulation. Any other intended purpose for massage therapy should be listed below:

____

____

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is NOT a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not a part of massage therapy.

I have informed the massage therapist of all known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. Any conditions not listed on the front sheet?_________________________

I have received a copy of the therapist's policies; I understand them and agree to abide by them.

____ ____________________

Client Signature Date