Massage Therapy
Patient Form

Name: _____ Date of Birth ____/____/____

Address: _____ Male / Female

_____

Home: _____

Cell: _____

Email: _____

I. Chief Complaint

Reason seeking Craniosacral Therapy/ Massage: _____

Is issue a result of: Car Accident Work Related Other _____

Have you seen any other doctor for this problem? Yes No Dr. Name _____

List any medications: _____

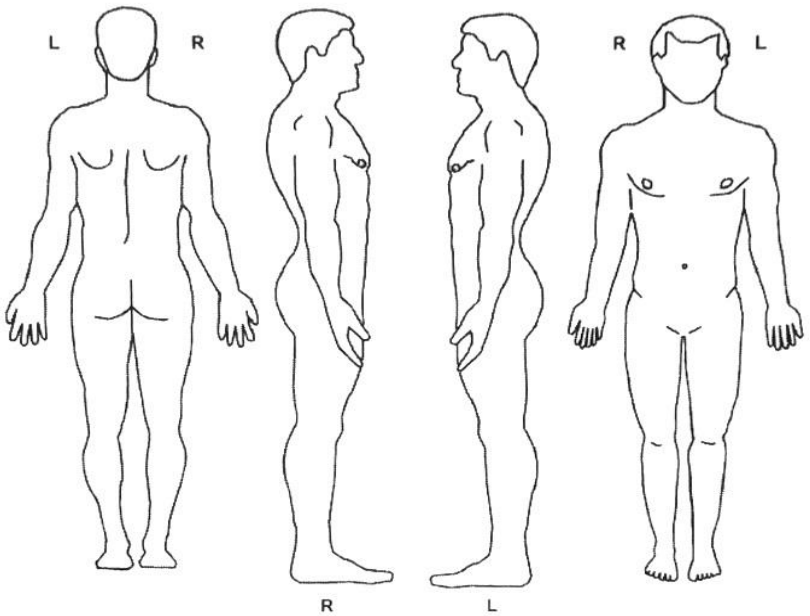
_____

What type of work do you do? _____

How many hours do you spend:

Sitting _____ Standing _____ Driving _____ in Manual Labor _____

Circle the areas where you have any problems
Please also describe these problems.



Mark as follows:
A - Ache B - Burning N - Numbness P - Pins & Needles
S - Stabbing O - Other - Describe _____

_____

_____

_____

_____

_____

_____

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_____

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_____

_____

Please check all that apply to you:

Sprains/Strains_____	Lupus _____	Kidney Stones _____
Metal Implants_____	Epilepsy _____	Bladder Infection _____
Arthritis_____	Muscle Spasms _____	Dizziness/Vertigo _____
Bursitis Tendonitis_____	Depression _____	Flu/Fever _____
Herniated Disc_____	Anxiety _____	Abdominal Pain _____
Sciatic Pain_____	Chronic Fatigue _____	Constipation _____
Low Arches_____	Insomnia _____	Allergies _____
Osteoporosis_____	Cardiac Problems _____	Sinus Problems _____
Numbness/tingling_____	Asthma _____	High/Low Blood Pressure _____
Cancer Migraines_____	Clotting Problems _____	Eating Disorders _____
_____	Varicose Veins _____	Skin Disorders _____
_____	Diabetes _____	Pregnancy _____ Weeks

Have you had any Concussions? YES / NO How Many?_____ When? _____

Have you had any Surgeries? YES / NO

Please explain: _____

_____

_____

II. Consent to Initiate Care

I, _____, consent to be a client of Christina Rappa. I understand that the purpose of the bodywork is to promote wellness and balance throughout the body using therapeutic techniques. The general benefits of Craniosacral Therapy, Massage, possible massage contraindications and treatment procedure have been explained to me. I have informed Christina Rappa of all my known physical conditions, medical conditions and medications and agree to update Christina Rappa if said conditions change. I understand that inappropriate behavior will not be tolerated and said therapist has the right to terminate at anytime throughout the session.

CANCELLATION POLICY: 24 hour notice is required for cancellations. Missed appointments will be charged the full fee for the session.

I certify that I have read and understand the consent form and procedure.

_____ _____

Patient/Guardian Signature Patient/Guardian Name (Printed) Date