Pilates Plus Wellness Center
301-952-1111 | 973-498-6955 (fax) | www.pilatespluscenter.com

MASSAGE HEALTH SCREEN

NAME_____DATE OF INITIAL VISIT_____

STREET_____

CITY, STATE, ZIPCODE_____

DATE OF BIRTH_____ REFERRED BY_____
E-MAIL_____CELL PHONE#_____
WORK PHONE#_____HOME PHONE#_____
OCCUPATION_____
INTEREST(S)_____

What is your previous experience with professional massage/other bodywork?

What is your goal/concern for today's session?

Is there any area where you would like extra time spent, any area where you seem to hold a lot of tension?

Any area you would like skipped?

Lifestyle:
Nutrition_____ Exercise_____
Tobacco_____Alcohol_____Drugs(non-med)_____
Posture assumed most of the day_____
Sleep_____ Bowels_____ Caffeine_____
Recreation_____
Do you wear contacts_____dentures_____ hearing aid_____

Are there specific aspects of your life that are particularly stressful (job, posture, habits, diet, family, etc? Explain.

Please See Page Two

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Medical History: (Give dates)

_____Hypertension
_____Heart disease
_____Arteriosclerosis
_____Varicose veins
_____Phlebitis
_____Fluid retention
_____Epilepsy
_____Fractures
_____Mental Illness
_____easy bruising
_____skin rash
_____abscess or open sore
_____skin sensitivity
_____ Headaches
_____Cancer/malignancy
_____Diabetes
_____ allergies
_____herpes I or II
_____other infectious diseases
_____pregnancy/now
_____intra uterine device
_____inner ear problem
_____fibromyalgia
_____fibrositis
_____chronic fatigue syndrome
_____herniated disc
_____PMS/painful menstruation
_____osteoporosis
_____osteoarthritis
_____rheumatoid arthritis
_____other_____

_____Any difficulty lying on your back, front or turning?

_____Are you taking any medicines? If so, what and what for?

_____Surgery/fractures (explain)(dates):

_____Implants of any kind:

_____Prior injuries (explain)(dates):

_____Musculoskeletal pain/stiffness (such as low back, neck, shoulder, etc.)(explain)(dates):

_____Any other physical or health difficulties:

To better develop a massage/bodywork session that meets your individual needs, it will be helpful to know if you have:

_____Any counseling history:

_____Any history of abuse (recent or past verbal, physical, sexual, emotional):

_____Any recent lifestyle/emotional challenge or loss:

_____Are you under the care of a physician or other medial practitioner now?____ A counselor?_____
For what condition(s):

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_____Do we have your permission to contact your physician should the need arise?

Name of Physician_____Phone_____

This information will be treated confidentially. In order to maximize the effectiveness and safety of massage sessions together, please give your feedback during and at the end of the sessions. This will help in tailoring the massage session to serve in the best possible way.

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

Signature_____ Date_____

(If client is a minor, parent/guardian sign above)