Welcome to the Uptown Wellness Center

Many health insurance plans cover **Massage Therapy**.
So that we may verify such benefits, please provide us with your **Health Insurance cards.**

PRINT CLEARLY - All information is required to ensure a safe & effective session.

Who referred you to our Center?

☐Referred by* ☐Internet website* ☐Health Fair/Event* ☐Met Doctor* ☐Yellow Pages* ☐Drove by

***Name**:_____

****Print Full Name of Patient, Doctor, Website, Directory or Event****

Client Information

Client's First & Last Name: _____
Email:_____
Home Phone #: ( )_____ Cell/Pager/Other #: ( )_____
Address: _____ Apt/Suite#:_____ City: _____ State: ___ Zip:_____
Date of Birth: _____ Gender: Male Female Marital Status: single married widowed divorced
Social Security #:_____ Driver's License #: _____
Employer:_____ Occupation:_____

Emergency Contact Name: _____ Tel #: ( ) _____
Relationship to Client:_____

Client Health Concerns & Lifestyle

Have you had a professional massage before? ☐ No ☐ Yes
If Yes, when was your last massage: ☐Last week ☐1-2 months ago ☐3-6 months ago ☐>6 months ago

Did you injure yourself recently? ☐No ☐Yes→ **How**? ☐Auto Accident ☐Work Injury ☐Other:
When did you injure yourself? Date: _____
Are you currently receiving treatment for this injury? ☐No ☐Yes→ _____

Do you have any difficulty lying on your front, back or side? ☐No ☐Yes→_____

Do you have any allergies to any lotions or sensitive skin? ☐No ☐Yes→_____

Are you wearing: ☐contact lenses ☐dentures ☐hearing aid ☐heart pacemaker
☐other device:_____

Where are your areas of concern? [Check all that apply & circle R=RIGHT, L=LEFT]

☐Head	☐R/L Shoulder	☐R/L Thigh	☐R/L Upper leg
☐Jaw	☐R/L Elbow	☐R/L Hip	☐R/L Lower leg
☐Neck	☐R/L Wrist	☐R/L Knee	
☐Upper back	☐R/L Hand	☐R/L Foot	
☐Mid-back	☐R/L Upper Arm	☐R/L Ankle	
☐Low back	☐R/L Forearm		

☐ Other: _____

Which other services & products may you be interested in at our Center?
☐ Spinal Decompression Therapy ☐ Kinesio-Tape ☐ Hot Stone Massage ☐ X-Rays ☐ Supports
☐ Acupuncture ☐ Chiropractic ☐ Physiotherapy ☐ Vitamins/Herbs ☐ Foot arch supports

Client Medical History & Information

Current Age: _____ Height: feet=____ inches=____ Weight: _____pounds
Date of Last Medical Exam: _____
Results of most recent…X-rays/CT/MRI: _____
Blood/Lab Tests: _____
Other Test Results/Findings: _____

All Prescribed Medications:_____
All Over-The-Counter Medications: _____
Do you have any congenital (from birth) factors which relate to your condition?
☐ No ☐ Yes→details/date: _____
Do you have any previous illnesses/complications from previous injuries?
☐ No ☐ Yes→details: _____
Have you ever been to the hospital for any reason (surgery, trauma, childhood, etc.)?
☐No ☐ Yes→details/date:_____
For Women: Is there any chance you may be pregnant: ☐ No ☐ Yes→# weeks: _____

Check the following that apply to you:

Yes	No		Yes	No	
☐	☐	Loss of consciousness/head injuries	☐	☐	Lupus
☐	☐	Seizures/Epilepsy/Convulsions	☐	☐	Diabetes
☐	☐	Dizziness/Fainting	☐	☐	Fibromyalgia
☐	☐	Visual disturbances/Eye problems	☐	☐	Hernia
☐	☐	Nose, throat, breathing problems	☐	☐	Osteoporosis
☐	☐	Asthma, allergies, allergic reactions	☐	☐	Sleep apnea/sleep conditions
☐	☐	Diarrhea, constipation	☐	☐	Menstrual problems
☐	☐	Numbness/loss of sensation	☐	☐	Urinary Bladder control problems
☐	☐	Abnormal/rapid weight gain/loss	☐	☐	Recent fever
☐	☐	High blood pressure	☐	☐	Rheumatoid arthritis
☐	☐	Artificial joints	☐	☐	Cancer/tumor/lumps:_____
☐	☐	Night sweats	☐	☐	Stroke – date:_____
☐	☐	Pain at night	☐	☐	Blood disease:_____
☐	☐	Pain unrelieved by position/rest	☐	☐	Alcohol/tobacco/drug abuse
☐	☐	Morning pain/stiffness	☐	☐	Recent fracture/broken bones
☐	☐	Easy bruising	☐	☐	Recent surgery
☐	☐	Varicose veins	☐	☐	Contagious skin condition
☐	☐	Atherosclerosis/hardening of arteries	☐	☐	Phlebitis
☐	☐	Open sores or wounds	☐	☐	Deep vein thrombosis/blood clots

Any Organ Problems/Diseases: ☐Heart ☐Liver ☐Kidney ☐Stomach ☐Pancreas ☐Gall bladder ☐Lungs ☐Intestines ☐Prostate ☐Uterus ☐Ovaries ☐Thyroid ☐Other:_____

Other health issues/concerns:_____

Before your session begins, your Massage Therapist will discuss your desired goals over the muscles of concern to you. Your Therapist will give you further guidance & discretely drape you so that you are always comfortable. Each session includes time for consultation and dressing. Please notify us in advance of any special requirements that you may need. We look forward to ensuring you have an enjoyable & relaxing experience!

I certify that the above information is complete & accurate to the best of my knowledge. I agree to notify this office immediately whenever I have changes in my health condition in the future.

Client Signature: _____ **Date**:_____