Sonja Pearson, LMT, Reiki Master
(207) 475-6878

Name_____ Today's Date_____
Street Address_____ Phone Number_____
City_____State_____ Zip_____ Best time to call_____
Date of Birth_____ Occupation, exercise routine, hobbies_____
Emergency contact Name and Phone_____
Referred By_____ E-mail address_____

Medical History
Reason for coming today _____
How do you want to feel at end of massage? _____
Are you Ticklish/areas to avoid?_____
Previous massage experience-likes and dislikes_____
_____
Are you currently under the care of a medical specialist (Please explain)_____
_____
Please list current medications/supplements:_____
_____
Sports/auto accidents/ broken bones (Please Include Dates)_____
_____
Surgeries/Medical Procedures (Please Include dates) _____
_____

Please check all that apply:

Musculoskeletal
□TMJ
□Limited range of motion
□Tendonitis
□ Plantar fasciitis
□Connective Tissue Disease
□broken bone
□Surgery
□Osteoporosis
□Dental work
□Arthritis
□Gout
Other_____

Circulatory
□Heart condition
□Phlebitis/Varicose Veins
□Blood Clots/Thrombosis
□High/Low BP
□arteriosclerosis
□Other_____

Nervous System
□Shingles
□Numbness/tingling
□Pinched nerve
□Migraines/ headache
□Epilepsy
□Tinitus
Other_____

Endocrine/Digestive/ Urinary
□Pancreatitis
□Diabetes
□Thyroid
□IBS
□Diverticulitis
□GERD
□Kidneys
□Cystitis
□StonesBladder dysfunction
Other_____

Integumentary/ Autoimmune/Respiratory
□Rash/Fungi
□Eczema
□Psoriasis
□Lymphedema, lymph
□Fever
□Lupus
□Fibromyalgia
□COPD/Chronic cough
□Allergies/
Asthma_____
Other_____

Other
□Cancer/tumor
□Sleep disorder
□Mental health (ex. Anxiety/ Depression/ADHD)
□Chronic pain
Other_____

I have completed the for to the best of my knowledge and will update my massage therapist each session. I am responsible for consulting a qualified medical professional for diagnosis and treatment. I understand that if I experience any discomfort during the session, I will immediately inform my therapist so he or she can modify the massage.

Signed _____ Date_____