Welcome to the Uptown Wellness Center

Many health insurance plans cover **Massage Therapy**. □Consult
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? ***Print Full Name of Patient, Doctor, Website, Directory or Event****

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

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 ☐ Laser Light Therapy ☐ Hot Stone Massage ☐ X-Rays ☐ Pillows
☐ Acupuncture ☐ Chiropractic ☐ Physiotherapy ☐ Vitamins/Herbs ☐ Foot arch supports

Client Medical History & Information

Current Age: _____ Height: feet=____ inches=____ Weight: _____pounds
Date of Last Medical Exam: _____ Medical Doctor's Name: _____
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:_____

For your benefit, you will receive a brief consultation to ensure a safe massage therapy session. You will have ample time to prepare, change & relax, all of which are inclusive of the time allotted. Your Personal Massage Therapist will give you further guidance & discretely drape you so that you are always comfortable. Please inform your therapist of any adjustments required in massage pressure intensity to ensure 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**:_____