806 W 10th St, Unit A
Austin, TX 78701
Phone: 512.481.2586
Geneva Sampson, LMT, CCMT #MT036702

Health Information

Patient Name ______________________ DOB __________ Today's Date __________

Referred by ____

A. Patient Information

Address ______________________

City/State/Zip ______________________

Best Phone # ______________________

B. Current Health Information

List Concerns that you would like addressed today. Check all that apply.

Primary ______________________

☐ mild ☐ moderate ☐ disabling

☐ constant ☐ intermittent

☐ symptoms ↑ w/activity ☐ ↓ w/activity

☐ getting worse ☐ getting better ☐ no change

treatment received ______________________

Secondary ______________________

☐ mild ☐ moderate ☐ disabling

☐ constant ☐ intermittent

☐ symptoms ↑ w/activity ☐ ↓ w/activity

☐ getting worse ☐ getting better ☐ no change

treatment received ______________________

Additional ______________________

☐ mild ☐ moderate ☐ disabling

☐ constant ☐ intermittent

☐ symptoms ↑ w/activity ☐ ↓ w/activity

☐ getting worse ☐ getting better ☐ no change

treatment received ______________________

List Daily Activities Limited by Concerns listed in prior section (if applicable).

List Self-Care Routines (if applicable)

How do you reduce stress? ______________________

How do you reduce pain? ______________________

List current medications (include pain relievers and herbal supplements?) ______________________

C. Health History

List and Explain. Include dates and treatment received (if applicable).

Surgeries ______________________

Major Injuries ______________________

806 W 10th St, Unit A
Austin, TX 78701
Phone: 512.481.2586
Geneva Sampson, LMT, CCMT #MT036702

Please check the appropriate box whether the following conditions currently exist or has existed in the past. If the condition does not apply to you, leave the spaces blank.

General			**Respiratory & Cardiovascular**			**Allergies**		
current	*past*	*comments*	*current*	*past*	*comments*	*current*	*past*	*comments*
		headaches			heart disease, blood clots			scents, oils, lotions
		sinus			asthma			detergents
		sleep disturbances			stroke			food
		fatigue			lymphadema	**Digestive/Elimination System**		
		infections			high, low blood pressure			bowel problems, ibs
Skin Conditions					irregular heart beat			abdominal pain
		rashes			poor circulation	**Endocrine System**		
		athlete's foot, warts			swelling			thyroid
Muscles and Joints					varicose veins			diabetes
		rheumatoid arthritis			chest pain, shortness of breath	**Reproductive System**		
		osteoarthritis	**Nervous System**					pregnancy
		spinal problems			numbness, tingling or shooting pain			cysts
		disk problems			sciatica	**Cancer/Tumors**		
		TMJ, jaw pain			dizziness, ringing in ear			benign
		spasms, cramps			carpal tunnel or thoracic outlet syndromes			malignant
		sprains, strains						
		tendonitis, bursitis						
		weak, stiff muscles or joints						

The therapist may use one or more of the following techniques today and on future appointments:

Crossfiber Corrective Muscle Therapy; Sports Massage; MyoFascial Release Therapy; Strain/Counterstrain movements; Range of Motion; Dynamic Stretching; Positional Release; Aromatherapy; Lymphatic Drainage; Vitaflex.

806 W 10th St, Unit A
Austin, TX 78701
Phone: 512.481.2586
Geneva Sampson, LMT, CCMT #MT036702

Please Read, Sign and Date

I understand that the soft-tissue therapy given at Blum Body Therapy, is for the purpose of relief from muscular tension, stress, muscle damage, and for improving circulation and general health. I understand that my massage therapist does **not** diagnose illness, disease, or any physical or mental disorder. As such, the massage therapist does **not** prescribe medical treatments or pharmaceuticals, nor do they perform any spinal manipulations. It has been made very clear to me that this soft-tissue therapy is not a substitute for medical examinations, and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Consent for Care

I promise to participate fully as a member of my health care team. I will make sound choices regarding my health plan based on any concerns, suggestions or general information my massage therapist or other members of my health care team may provide. I will inform my therapist any time I feel my well-being is threatened or compromised. I expect my massage therapist to provide soft-tissue therapy that is both safe and effective.

Because my massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and **take it upon myself to keep the massage therapist updated on my physical health changes**. Draping **will be** provided during each session, and breast massage will **not** be done without previous discussion and permission of the client. If the client or therapist feels uncomfortable at any time, he/she may terminate the session. I am making an informed choice to receive massage therapy.

☐ I would like to be added to your email newsletter.

Patient/Guardian Signature ______________________________ Date ____________________

Therapist Signature ____________________________________ Date ____________________

For Therapists Only

Treatment Goals

☐ Decrease Pain
☐ Decrease Inflammation
☐ Decrease Muscle Tension/Spasms
☐ Decrease Compensatory Patterns
☐ Increase Mobility
☐ Increase Strength
☐ Restore Function
☐ Restore Posture
☐ Patient Education
☐ All of the Above
☐ Other ___________________________