DR. JAY RAPPAZZO
INTEGRATED HEALTH SPECIALIST

Massage Therapy Health History
Patient Information Sheet

Name: _____

Date of Birth (day/month/year): _____/_____/_____

Address: _____

City: _____ Postal Code: _____

Telephone Number: Home: (_____) _____-_____ Cell: (_____) _____-_____

Occupation: _____

Marital Status and Children: _____

Family Doctor's Name: _____

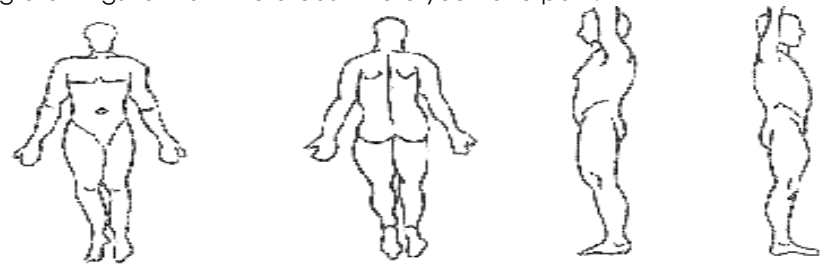
Referring Doctor's Name: _____

Smoking: Yes □ No □ cigarettes/day: _____

Please answer the following questions:

1. What are the main reasons you wish to see the Massage Therapist? (please circle)
   - Pain
   - Fatigue
   - Sleep Problems
   - Menstrual Problems
   - Other Problems (please specify): _____

2. Please use the following drawings to mark the areas where you have pain:



3. Mark in this scale, what is your level of pain today (T), and in general (G) (0 = no pain):

1 2 3 4 5 6 7 8 9 10

4. Circle the treatment that you have received so far for your pain/fatigue or other problems?
   - Medication
   - Physical Therapy
   - Chiropractic
   - Massage Therapy
   - Other Treatments (please specify): _____

5. So far, which treatments have benefited you the most? _____

6. List all the medications and supplements you are taking, or have taken recently:

_____

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Please answer the following questions about your family medical history:

Has anyone in your family had Heart Disease?
- High Blood Pressure
- Diabetes
- Cancer
- Other Disease (please specify): _____

Please circle the appropriate symptoms if you have ever experienced if:

Head and Neck

Headaches	Hearing Problems	Ringing of the Ears	Cavities
Vertigo	Dizziness	Eye Problems	Other Mouth Problems
Vision Problems	Nose Problems	Temporomandibular Problems	Sore Throat
Sinusitis	Neck Pain	Voice Changes	

Other Problems in there areas (specify): _____

Chest, Lung, and Skin

Chest Pain	Palpitations	Blood Pressure Problem	Allergies
Tachycardia	Chest Oppression	Excessive Dreaming	Skin Problems
Insomnia	Night Sweats	Excessive or Little Sweating	Restlessness, Irritability
Lung Problems	Asthma	Shortness of Breath	

Other Problems in there areas (specify): _____

Digestive System and Miscellaneous

Bleeding Gums	Belching	Nausea, Vomiting	Hemorrhoids
Heart Burning	Poor Appetite	Loss of Taste	Varicosities
Bloating	Abdominal Pain	Bowel Movements After Meals	Heavy Legs
Sleepy After Meals	Gas, Rumbling	Diarrhea	Bruising Easily
Constipation	Gaining or Losing Weight Easily		

Other Problems in there areas (specify): _____

Gynecological System

Painful Periods	Heavy Periods	Irregular Periods	Fertility Problems
Long Periods	Absent Periods	Pre-Menstrual Syndrome	Breast Problems
Hot Flashes	Endometriosis	Painful Intercourse	Miscarriages, Abortions

Other Problems in there areas (specify): _____

Liver and Gall Bladder

Liver Problems	Sweaty Palms	Sweats Easily	Slow Digestion
Irritated Easily	Brittle Nails	Bitter Taste in Mouth	Restlessness
Muscle Cramps	Anxiety	Tension	

Other Problems in there areas (specify): _____

Kidney, Urinary Tract, Endocrine System and Various

Kidney Stones	Kidney Problems	Urinary Bladder Problems	Weak or Sore Knees
Prostatitis	Frequent Urination	Urinary Tract Infections	Low Back Pain
Incontinence	Low Sexual Drive	Erectile Dysfunction	Bone Problems
Feeling Cold	Feeling Hot	Feeling Low Energy	
Cold Hands	Cold Feet	Joint Pain	

Please mention any muscle/joint problems anywhere else: _____

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Informed Consent for Massage Therapy

Dr. Jay Rappazzo DC, RMT, DAc

Please Read Carefully

I, the undersigned, to hereby give my voluntary consent for the administration of massage therapy and active release techniques as deemed appropriate by my treating massage therapist.

I understand that there is the possibility of temporary complications that may result from massage therapy procedures, which include, but are not limited to bruising, soreness, nausea, weakness, fatigue, fainting, or aggravation of existing symptoms for a short time. On the rare occasion, an individual may experience convulsions or seizures.

I further state that the following **do not** exist in my current state of health and I will immediately notify the practitioner of any changes:

Pregnancy	Local Infections	Pacemaker
Anticoagulants	Bleeding Disorders	Elevated Risk of Infections

I do not expect the massage therapist to be able to anticipate and explain all possible risks and complications. I wish to rely on the therapist, to exercise proper judgment during the course of the treatment to make decisions based upon my best interests.

I accept the fact that there is no guarantee of the effectiveness of the treatment.

I am aware that I may withdrawal this consent and discontinue treatment at any time.

I hereby certify that I have read the above information and have had my questions answered to my satisfaction. By signing below, I agree and provide my full voluntary informed consent to the above-mentioned massage therapy treatments.

Date: _____

Patient Name (printed): _____

Patient Signature: _____

Therapist: _____