Integrative Massage & Body Therapy

www.MarkRobers.com • 414-2780-0440 • Imbt827@yahoo.com

3970 N. Oakland, Ste. 502, Shorewood, WI 53211

Name ____ DOB_____________

Address____

City ___________________________________ State _________ Zip______________________

Telephone (H)__________________(O)___________________(Cell)______________________

Email ____ Today's Date____________________

Occupation_________________________________ Referred By____________________________

Major Complaint____

Area of concern ____

When did you 1st notice the concern ____

What brought it on ____

Is the concern getting worse _______Constant ________comes/goes_______

Is it interfering with work ________ Sleep ______Daily Routines________

What do you believe is wrong ____

What has brought relief ____

Has there been a diagnosis _________________By Whom_____________________________________

Has this occurred before ____

Treatments ____

Your Physician ____

Have you had any Operations ____

Broken bones____

Accidents, Falls ____

Whiplash ____

Have you had Massage before ____

Are you pregnant ___________________________ How many pregnancies_____

Do you wear arch supports ______________________heel lifts___________

What side do you sleep on?____

(Over)

Do You Have Difficulty With Any of the Following?

_____ Headaches
_____ Shooting head pain
_____ Sinus troubles
_____ Hay fever
_____ Head feels too heavy
_____ Loss of balance
_____ Painful joints
_____ Pinched nerve
_____ Digestive troubles
_____ Cold hands
_____ Chest pains
_____ Pins & needles in arms, hands
_____ Shortness of breath
_____ Dizziness
_____ Glasses
_____ Arthritis
_____ Pins & needles / legs & feet
_____ Inner tension
_____ Asthma
_____ Tightness in throat
_____ Blood sugar high/low
_____ Thyroid
_____ Fainting
_____ Light bothers you
_____ Slipped disk
_____ Swollen ankles

Are You Using Any of the Following?

_____ pain medication
_____ sedatives
_____ supplements
_____ caffeine
_____ sugar
_____ anti-inflammatory
_____ vitamins
_____ herbs
_____ tobacco
_____ alcohol
_____ muscle relaxants
_____ insulin
_____ coffee
_____ tea
_____ sleep aids

I AGREE TO A 24 HOUR CANCELLATION/FAILURE TO SHOW POLICY, OR I WILL BE SUBJECT TO PAYMENT FOR SESSION YES ____ NO _____

SIGNATURE____