Kuhl Massage, Dianah Kuhl-Troemel, BA, LMT Phone: 618.578.1808

Name: _____
Address: _____
City: _____ St: _____ Zip: _____ Date of Birth:_____
Cell Phone: _____ Work Phone: _____ Home Phone: _____
Email Address: _____
Do I have permission to email confirmation appointment reminders ? Yes or No
Reason For Massage: _____Referred By: _____
Occupation _____ Military/Branch/MOS: _____
Emergency Contact Person: _____ Phone # _____
Primary Physician: _____ Phone # _____

Please circle the appropriate answer for each question.

1. Have you had a professional massage before: Yes or No
2. Are you pregnant or do you think you may be pregnant: Yes or No (If yes, Due Date _____)
3. Do you wear contact lenses? Yes or No
4. Do you wear dentures? Yes or No
5. Have you ever had surgery? Yes or No If yes, please list below.
6. Have you ever suffered an acute injury recently (past 72 hours) or been in an auto collision? Yes or No
7. Do you take prescribed medications? Yes or No **If yes, please list below**.
8. Do you take herbal supplements or vitamins? (Circle one that applies) Yes or No
9. Have you been diagnosed with arthritis? Yes or No What type? Rheumatoid, Osteoarthritis, Other
10. Have you been diagnosed with any heart problems? Yes or No
11. Have you been diagnosed with blood pressure problems? Yes or No
12. Have you been diagnosed with any spinal problems? Yes or No If yes, what? _____
13. Have you been diagnosed with varicose veins or blood clots? Yes or No
14. Do you exercise or participate in any sport? Yes or No
15. Do you have skin problems or skin sensitivities to lotions, oils, etc? Yes or No
16. Do you have allergies? (scents, pollen, mold, ….) Yes or No
17. Are you currently seeing a medical professional for ANY condition? Yes or No **Please list below.**
18. Do you have any other medical condition of which I should be aware of before receiving a massage? Yes or No
19. Do you see a chiropractor or an acupuncturist? Yes or No

Past Injuries/Trauma (date & brief description): _____

Any vehicle accidents (date & brief description): _____

Please list all surgeries: _____

Please list all medications or herbal supplements that you are taking:

_____

Conditions being treated for:_____

I understand that massage therapy and/or hot & cold rock therapy, given here is for the purpose of stress reduction, relief from muscular tension or spasm or for increasing circulation.
I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. It has been made very clear to me that massage is not a substitute for medical exams and/or diagnosis and that it is recommended that I see a physician for any physical problem that I may have.
Because the 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.
There is no charge for appointments cancelled & rescheduled at least 24 hours before appointment time. You will be charged the full amount for failing to show up for a scheduled appointment.
I understand that my records are protected under federal & state regulations & cannot be disclosed without my express written consent. I further agree that I will not hold the therapist responsible should there be any unfavorable outcome or result.

Sign: _____ Date: _____