

Independent Massage Therapist  
**WELLNESS CHART**

Name \_\_\_\_\_ ID#/DOB \_\_\_\_\_ Date \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_ Email \_\_\_\_\_

1. What are your goals for health, and how may I assist you in achieving your goals? \_\_\_\_\_  
 \_\_\_\_\_

2. List typical daily activities – work, exercise, home. \_\_\_\_\_  
 \_\_\_\_\_

3. Are you currently experiencing any of the following? If yes, please explain.

pain, tenderness     No     Yes \_\_\_\_\_      stiffness     No     Yes \_\_\_\_\_  
 numbness or tingling     No     Yes \_\_\_\_\_      swelling     No     Yes \_\_\_\_\_  
 allergies     No     Yes \_\_\_\_\_

4. List all illness, injuries and health concerns you have now or have had in the past 3 years.  
 (Examples: arthritis, diabetes, car crash, pregnancy) \_\_\_\_\_  
 \_\_\_\_\_

5. List medications and pain relievers taken this week. \_\_\_\_\_

6. I have provided all my known medical information. I acknowledge that massage therapy is not a substitute for medical diagnosis and treatment. I give my consent to receive treatment.

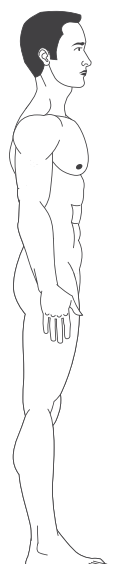
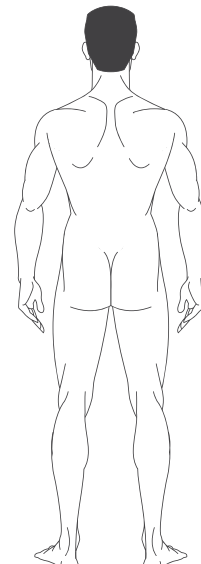
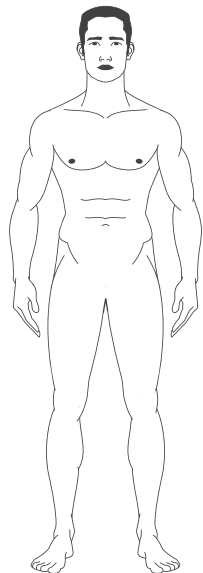
Signature \_\_\_\_\_ Date \_\_\_\_\_

Tx: \_\_\_\_\_

C: \_\_\_\_\_

**Legend:**

- ⊙ TP
- TeP
- ⊙ ⊕
- \* Infl
- ≡ HT
- ≈ SP
- × Adh
- ⇄ Numb
- ↻ rot
- / elev
- ↔ Short
- ↔ Long



initials \_\_\_\_\_