Synchronicity
OSTEOPATHIC-BASED BODYTHERAPY
303 Fifth Ave. (31st St), Suite 712, New York, NY, 10016
Tel & Text: 212-683-9600 www.SynchronicityMassage.com

INFORMATION FOR MASSAGE THERAPY

Please answer the following questions so that we may have a better understanding of your general health and lifestyle to enable us to custom-design your session. All information is strictly confidential.

PLEASE PRINT

Last Name: _____ First Name _____ Middle Initial ____ Date of birth: _____ ☐ Male ☐ Female

Home Address: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Marital Status: _____ Referred By: _____ Email: _____

Height: _____ Weight: _____ BMI: (Off.Use) . . . . Average amount of water you drink daily: _____ (oz)

Primary reason for massage therapy: _____

If in pain, how often does it hurt? Where? _____ Intensity of pain from 1 to 10: ("10" is unbearable) ____

What relieves the pain? _____

Healthcare professionals (MDs, Chiropractors, etc) you have consulted for the above discomfort? Please list types of treatments with dates:

History of injuries, illnesses and/or surgeries with dates:

Medications you are currently taking and for which condition:

Medication	For Treatment Of	Dose/Amt. per day	Effectiveness

Supplements you are currently taking: _____

Current Occupation: _____ Past Occupation(s): _____

Regular physical activities or sports? How often? _____ Hobbies: _____

Are you pregnant? ☐YES ☐ NO If yes, due date: _____ Do you have any children? _____

Your Physician Name and Phone: _____ Your Specialist Name and Phone: _____

Emergency contact (name and phone): _____

GENERAL MEDICAL HISTORY (please highlight)

CARDIOVASCULAR
- ❑ Chronic congestive heart failure
- ❑ Family history of cardiovascular problems
- ❑ Heart attack
- ❑ Heart disease
- ❑ Hemophilia
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Pacemaker
- ❑ Phlebitis / varicose veins
- ❑ Poor circulation
- ❑ Stroke

DIGESTIVE SYSTEM
- ❑ Cholesterol, elevated
- ❑ Colitis
- ❑ IBS / IBD
- ❑ Stomach ulcer

HEAD & NECK
- ❑ Headaches/migraines
- ❑ Hearing loss
- ❑ Ringing in ears
- ❑ Vertigo/dizziness
- ❑ Vision loss
- ❑ Vision problems

INFECTIONS
- ❑ Hepatitis
- ❑ Herpes
- ❑ HIV / AIDS
- ❑ Infectious skin conditions
- ❑ Lyme disease
- ❑ Tuberculosis

MUSCULOSKELETAL
- ❑ Bursitis
- ❑ Carpal tunnel
- ❑ Family history of arthritis
- ❑ Heel spur/plantar fasciitis
- ❑ Hernia
- ❑ Jaw pain (TMJ)
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Pins / plates/ wires / artificial joints
- ❑ Sciatica
- ❑ Scoliosis
- ❑ Sprains (joint)
- ❑ Strain (muscle)
- ❑ Tendonitis
- ❑ Whiplash

NERVOUS SYSTEM
- ❑ Epilepsy
- ❑ Multiple sclerosis
- ❑ Numbness/tingling
- ❑ Paralysis
- ❑ Parkinson's disease
- ❑ Sciatica
- ❑ Seizures
- ❑ Sensory loss/change
- ❑ Vertigo

RESPIRATORY
- ❑ Asthma
- ❑ Bronchitis
- ❑ Chronic cough
- ❑ Emphysema
- ❑ Family history of respiratory disease
- ❑ Frequent colds
- ❑ Pneumonia
- ❑ Shortness of breath
- ❑ Sinusitis
- ❑ Smoker

REPRODUCTIVE
- ❑ C-section delivery
- ❑ Gynecological problems
- ❑ Low libido
- ❑ Pelvic pain

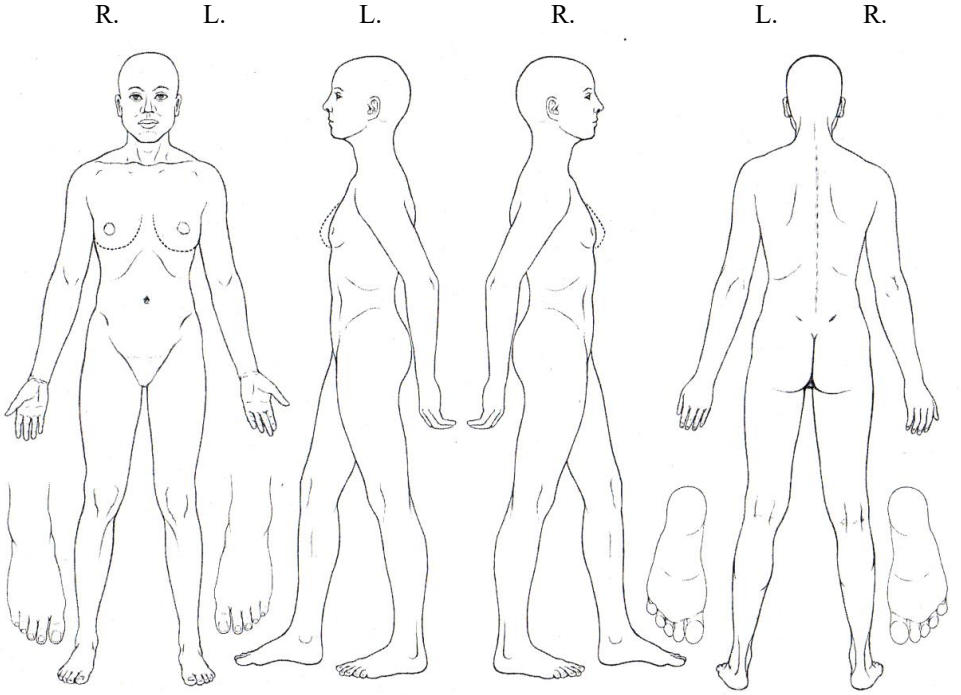
OTHER CONDITIONS
- ❑ Anxiety
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Fibromyalgia
- ❑ Hormone imbalance
- ❑ Hyperglycemia
- ❑ Hypoglycemia
- ❑ Incontinence
- ❑ Kidney /bladder disease
- ❑ Liver/gallbladder disease
- ❑ Lymphadenectomy
- ❑ Motor vehicle accident
- ❑ Psychiatric problems
- ❑ Radiation treatment
- ❑ Scars
- ❑ Unexplained weight loss
- ❑ Vaccinations:
  - Influenza
  - Covid19
  - Shingles
  - Others:

OTHERS: _____

Do you have any of the following TODAY? Please highlight all that applies.

- ☐ Bruises
- ☐ Burns (sun or radiation)
- ☐ Cold / Flu / Fever
- ☐ Headache
- ☐ Irritated skin rash
- ☐ Inflammation
- ☐ Open cuts / infection
- ☐ Poison ivy/oak

Please circle the areas of concern on the diagram:



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Lateness and Cancellation

- Lateness. The client is financially responsible for the entirety of the scheduled appointment
- Cancellation/Reschedule. Full payment for LESS THAN 24-HOUR NOTICE

Payment

- Payment must be received at the time of the appointment with cash, check, Zelle or PayPal
- Pay with PayPal: 3.5% transaction fee will be added to the charge
- We DO NOT accept credit card payment
- Returned check fee: up to $35 per check
- Upon request, we will provide you a receipt with insurance code for your insurance submission

PLEASE READ AND SIGN:

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers in my care and treatment.

Treatments may be covered by extended health care plans. I understand that it is my responsibility to confirm the exact details of my coverage.

I understand that I will be responsible for the full payment for the appointment if cancellation or reschedule is less than 24 hours

Print Name: _____ **Date:** _____

Signature: _____