



# Rhemed by Rhed

Therapeutic Massage & Bodycare by Judie Rhed Yim

230 W13th St #LL-1B NYC 10011 or 295 St Marks Ave #1A Bklyn 11238 347.284.0086 info@rhemedbyrhed.com

PERSONAL INFORMATION		
Name:	Today's Date (mm/dd/yyyy):	
Date of Birth (mm/dd/yyyy):	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address:		
City:	State:	Zip:
Cell Phone:	Email:	
Your Occupation:	Employer:	

In case of emergency, who should we notify?	
Relation to you?	Contact Number:
How did you hear about us: <input type="checkbox"/> Yelp <input type="checkbox"/> Google <input type="checkbox"/> Health Professional <input type="checkbox"/> Other internet _____ <input type="checkbox"/> Other _____	

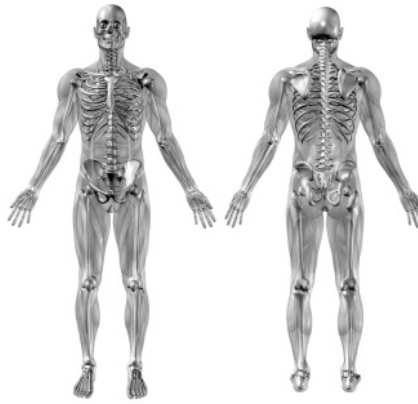
REASON FOR APPOINTMENT	
What is your chief complaint? (for relaxation purposes, please skip the below sections)	
Describe the onset:	
Provide primary symptoms and rate them mild, moderate or severe:	
Please rate your pain on the scale from 1 to 10:	
Have you seen any other physicians or healthcare professionals for this complaint?	
If Yes, Doctor's name	Date of last treatment:
Diagnosis:	What type of treatment did you receive?
Have the treatments worked?	
List current medications, including aspirins, antihistamines, birth control, supplements and their purpose:	
Describe your current lifestyle (habits, physical activities, sleep patterns, emotional state):	
Do you have allergies to any oils or essences?	Do you dislike any oils or essences?
Do you have any other allergies ie nuts or fruits?	

Note the areas of:

X = pain

O = tightness

N = numbness



**HEALTH HISTORY**

Please check the appropriate circle of any of the following symptoms that you now have or have had previously

**C = Constant F = Frequent O = Occasional**

C F O	C F O	C F O	C F O
<p><b>Muscle &amp; Joint</b></p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Tension</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Spasm/cramps</p> <p>Location:</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Sprains/ Strains</p> <p>Location:</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Low back/ hip pain</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Leg pain</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Knee pain</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Buige/slipped disks</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Neck/shlder pain</p> <p>Location:</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Whiplash</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Tendonitis</p> <p>Location:</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Bursitis</p> <p>Location:</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Broken/ Fractured bones</p> <p>Location:</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Flat fee</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> High arches</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Jaw pain/ TMJ</p>	<p><input type="radio"/> <input type="radio"/> <input type="radio"/> Arthritis</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Fibromyalgia</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Osteoporosis</p> <p><b>Skin</b></p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Dryness</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Skin rash</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Eczema/Psoriasis</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Athlete's Foot</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Warts</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Bruise easily</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Acne</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Open wounds/</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Hives or allergy</p> <p>Location:</p> <p><b>Nervous System</b></p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Numbness/tingling</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Herpes/ Shingles</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Fatigue</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Chronic Pain</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Bell's Palsy</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Trigeminal Neuralgia</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Paralysis</p>	<p><b>Respratory</b></p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Chronic cough</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Asthma</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Allergies</p> <p>Type:</p> <p><b>Cardlo-vascular</b></p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Heart condition</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Varicose Vein</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Blood clots</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> High blood pressur</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Low blood pressure</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Lymphedema</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Hemophilia</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Stroke</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Arteriosclerosis</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Phlebitis</p> <p><b>Digestive</b></p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Gastro Intestinal</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Constipation</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> IBS/Crohn's</p>	<p><b>Genito-Urinary</b></p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Kidney Infection</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Pregnant</p> <p>Months:</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Irregular</p> <p>Menstruation</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Infertility</p> <p><b>Other</b></p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Common cold</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Headache</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Eye Strain</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Drugs/ Alcohol</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Caffeine</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Epilepsy/Seizures</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Cancer/ Tumors</p> <p>Type:</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Diabetes</p> <p>Type:</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Mental health</p> <p>Type:</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Infectious Disease:</p> <p>Type:</p>

**Disclaimer:**

I understand that the massage session I receive is for the purpose of relaxation and stress reduction, promotion of balance and normalization of the body, and stimulation of circulation thereby delivery of oxygen and nutrients to the cells. If I experience pain or discomfort during the session, I will immediately inform my therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that I may discontinue a session or sessions at any time.

Because massage is contraindicated under certain medical conditions, I affirm that I have stated all of my known medical conditions, and have answered all questions honestly. I agree to keep my massage therapist updated as to any change in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

I understand that a Massage Therapist is not qualified to practice medicine, diagnose, prescribe or treat any physical or mental illnesses and that nothing said in the course of the session(s) given should be construed as such. Massage is not a substitute for medical treatment, but is a complement to most types of therapy.

If I am not able to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case, I will call ASAP to reschedule my appointment. If I miss a scheduled appointment without giving 24 hour notice, I agree pay any missed appointment charge applicable.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name