****CONFIDENTIAL****

CLIENT INFORMATION & HEALTH HISTORY

GENERAL INFORMATION

Name: ______________________________

Address: ______________ City: ______________ State: ______ Zip: ______________

Email: ______________ Phone: ______________ O home O cell O work

Emergency Contact: ______________ Phone: ______________ Relationship: ______________

Employer: ______________ Occupation: ______________

Referred By: ______________________________

MEDICAL INFORMATION

Is this your first professional massage? O yes O no

If no, how frequently do you get a massage? ______________________________

What do you hope to accomplish from today's massage? ______________________________

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Are you aware of any tension-holding spots in your body? O yes O no

If yes, where? ______________________________

Describe any surgeries, hospitalizations, accidents, or injuries you have had:

In the past 5 years: ______________________________

More than 5 years ago: ______________________________

What kind of care did you receive? ______________________________

Do you feel that you have recovered from these events? O yes O no

If no, please explain: ______________________________

Do you have any chronic/ongoing pain that you deal with on a regular basis? O yes O no

If yes, please explain: ______________________________

Describe what activities cause this pain and/or make it worse: ______________________________

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Are you currently receiving any medical treatment? O yes O no

If yes, please explain: ______________________________

Please list any medications (vitamins, herbs, or pharmaceuticals) taken now or at regular intervals (include explanation of what medication is used to treat):

____

Are you currently under the care of a physician? O yes O no

If yes, provide name: ______________________________

Please list reason(s): ______________________________

Are there any other health concerns you wish to discuss today? O yes O no

If yes, please explain: ______________________________

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Are you currently experiencing any of the following conditions?

- O Flu
- O Cold
- O Fever
- O Inflammation
- O Infection

Concerns or additional information you want your therapist to know:

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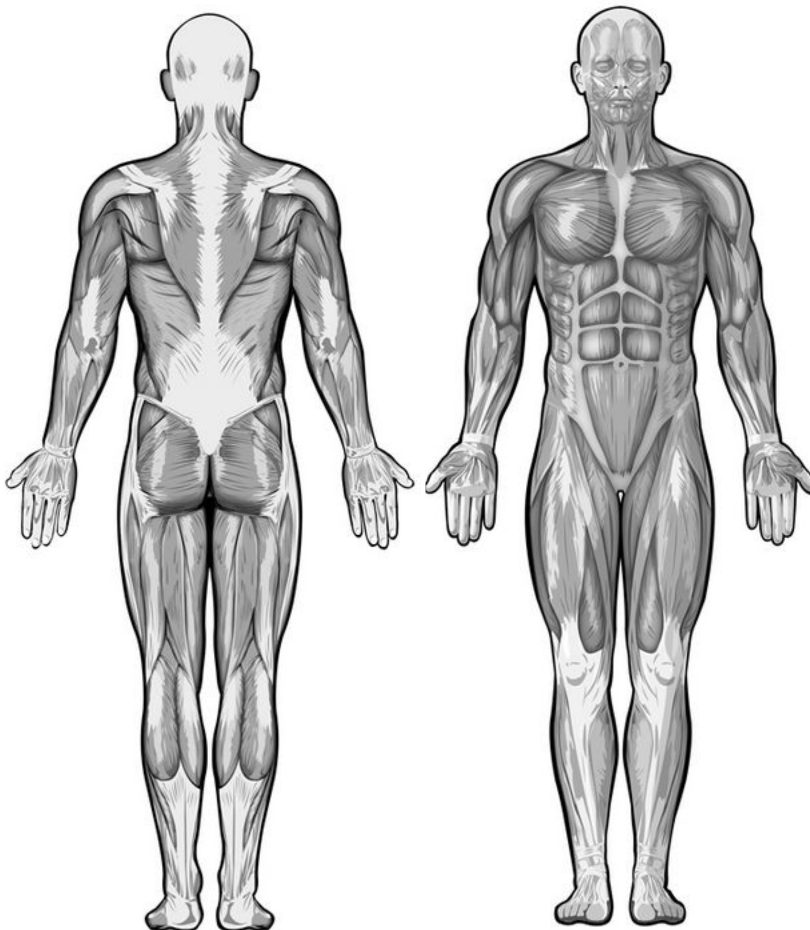
Using the body diagrams below, please indicate any areas where you are feeling discomfort:



Please check any of the following conditions below that currently affect you or that you have experienced in the past 5 years.

MUSCULOSKELETAL

- O Fibromyalgia
- O Spasms/Cramps
- O Sprains/Strains
- O Osteoporosis
- O Postural Deviations
- O Gout
- O Osteoarthritis/ Rheumatoid Arthritis
- O TMJ
- O Cysts
- O Bursitis
- O Plantar Fascitis
- O Tendonitis
- O Torticollis
- O Whiplash Syndrome
- O Carpal Tunnel Syndrome
- O Sciatica
- O Thoracic Outlet Syndrome
- O Headache
- O Leg Pain
- O Arm Pain/Shoulder Pain
- O Low Back Pain
- O Mid Back Pain
- O Hip Pain
- O Other__________________

RESPIRATORY

- O Pneumonia
- O Sinusitis
- O Asthma
- O Trouble Breathing
- O Dizziness
- O Other__________________

CIRCULATORY

- O Aenemia
- O Hemophilia
- O Hypertension
- O Low Blood Pressure
- O Raynaud's Disease
- O Varicose Veins
- O Heart Condition
- O Blood Clots/Plebitis
- O Diabetes
- O Other __________________

DIGESTIVE

- O Ulcers
- O Irritable Bowel Syndrome
- O Colitis
- O Gallstones
- O Hepatitis
- O Crohn's Disease
- O Diarrhea
- O Gas/Bloating
- O Indigestion
- O Other __________________

SKIN

- O Fungal Infections
- O Acne
- O Impetigo
- O Dermatitis/Exczema
- O Open Wound or Sore
- O Rashes
- O Warts/Moles
- O Athlete's Foot
- O Other __________________

NERVOUS SYSTEM

- O ALS
- O Multiple Sclerosis
- O Parkinson's Disease
- O Bell's Palsy
- O Neuritis
- O Spinal Cord Injury
- O Stroke
- O Trigeminal Neuralgia
- O Seizure Disorders
- O Numbness/Tingling/ Twitching
- O Other __________________

OTHER

- O Insomnia
- O Anxiety/Panic Attacks
- O PMS
- O Grief Process
- O Cancer
- O Substance Abuse
- O Pregnancy
- O Chronic Fatigue
- O HIV/AIDS
- O Lupus
- O Kidney Disease
- O Bladder Infection
- O Postoperative Situation
- O Edema
- O Other __________________

The information on this form is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications, or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I also understand that cancelled appointments without 24 hours notice (medical emergencies excluded) may be charged in full for the price of the missed session.

SIGNATURE ____ **DATE** ______________________

PRINT NAME ____