Confidential Client Information and Health History

PERSONAL DATA

Name: _____ Date: _____

Height: _____ Weight: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (c) _____ (w) _____ (h) _____

Email Address: _____ Preferred Contact Method:

Occupation: _____ Referred By: _____

Emergency Contact: _____ Phone: _____

MASSAGE HISTORY / TREATMENT INFORMATION

Have you ever received a professional massage? ☐ Yes ☐ No

If yes, frequency: _____ Date of last massage: _____

What results do you want from your massage session? (e.g. relaxation, pain relief, reduce stress)

_____

Indicate area(s) of your body that you give permission to receive massage:

☐ Head ☐ Face ☐ Neck ☐ Chest ☐ Abdomen ☐ Hands

☐ Back ☐ Arms ☐ Buttocks ☐ Legs ☐ Feet

Are there areas where you do NOT want to receive massage: _____

Are you currently seeing a medical practitioner: ☐ Yes ☐ No

If yes, explain: _____

List stress reduction and exercise activities. Include frequency. _____

_____

List current medications, including aspirin, ibuprofen, etc. _____

_____

MEDICAL HISTORY (include year and treatment received)

Surgeries: _____

_____

_____

Accidents: _____

_____

_____

(Please remember to check and sign back)

HEALTH HISTORY (check all that apply)

MUSCULO-SKELETAL

- ☐ bone or joint disease _____
- ☐ tendonitis _____
- ☐ bursitis _____
- ☐ broken / fractured bones _____
- ☐ arthritis _____
- ☐ neck, shoulder, arm pain _____
- ☐ low back, hip, leg pain _____
- ☐ headaches / head injuries _____
- ☐ spasms / cramps _____
- ☐ jaw pain / TMJ _____
- ☐ sprains / strains _____
- ☐ other _____

CIRCULATORY

- ☐ heart condition _____
- ☐ varicose veins _____
- ☐ blood clots _____
- ☐ high blood pressure _____
- ☐ low blood pressure _____
- ☐ lymphedema _____
- ☐ breathing difficulty _____
- ☐ sinus problems _____
- ☐ allergies _____
- ☐ other _____

INFECTIOUS DISEASE

_____

Anything else you wish to include? _____

_____

_____

_____

SKIN

- ☐ allergies _____
- ☐ rashes _____
- ☐ athlete's foot _____
- ☐ warts _____
- ☐ other _____

DIGESTIVE

- ☐ constipation _____
- ☐ gas / bloating _____
- ☐ diverticulitis _____
- ☐ IBS _____
- ☐ other _____

NERVOUS SYSTEM

- ☐ herpes / shingles _____
- ☐ numbness / tingling _____
- ☐ chronic pain _____
- ☐ fatigue _____
- ☐ sleep disorders _____

REPRODUCTIVE

- ☐ pregnant? stage _____
- ☐ PMS _____
- ☐ other _____

OTHER

- ☐ cancer / tumors _____
- ☐ diabetes _____
- ☐ eating disorders _____
- ☐ depression _____
- ☐ drug / alcohol addiction _____
- ☐ nicotine / caffeine addiction _____
- ☐ other _____

The above information is accurate and true to the best of my knowledge. It is my choice to receive massage therapy. I realize that the treatment is being given for the well being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my massage therapist any time I feel my well being is being compromised.

I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorders, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my health status and understand that there shall be no liability on the practitioner's part if I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for full payment of the scheduled appointment.

SIGNATURE: _____ DATE: _____