Confidential Massage Client Information and Health History

Full Name: ____ Date of Birth ____/____/_____
Last First MM DD YYYY

Address: ____ City: _________________ State: _____ Zip: ______

Phone: (_____) ______ - ________ Cell Phone: (_____) ______ - ________ E-mail: ________________________

Age: _____ M: __ F: __ Marital Status: ___________ Occupation: _____________________

Emergency Contact: ________________________________ Phone: _________________ Relationship: __________

How did you hear about us/referred by? ____

Have you previously had massage or other bodywork? ______ If yes, what type? ____________________________

How frequently do you receive massage? ____

What is the main reason for your massage today? ____ Relaxation/Stress Relief ____Pain Relief

Other ____

Please indicate any sports or other activities you engage in on a regular basis and their frequency:

____

Are you pregnant?____________________ Allergies to oils/perfumes?_______________ Wear contacts?_________

Have you consumed alcohol in the past 24 hours? ____________

Are you currently experiencing any of the following conditions? ____Flu/Cold ____Inflammation/Swelling ____Fever

Are you currently under the care of a physician for a specific medical issue?______ If yes, please indicate below:

____

____

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

Less than 5 years ago:

____

____

More than 5 years ago:

____

____

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

____

____

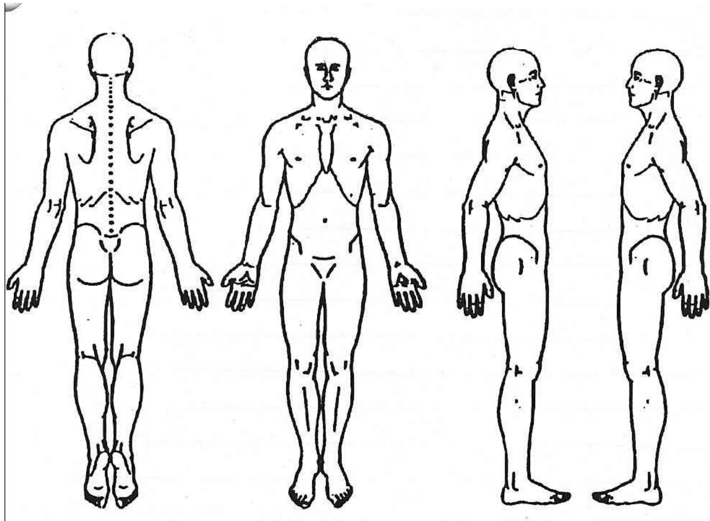
Do you have any chronic, ongoing pain that you deal with on a regular basis? _____ Please explain:_____________

____

What activities cause this pain? What makes it feel better? Worse?

____

Please indicate with an X, where you experience pain and/or tension on the drawing below:



Please indicate if your consumption is:

	None	Light	Moderate	Heavy
Salt				

Are there any other health concerns you wish to discuss today? ______ If yes, please describe__________________

____

Please check (?) any of the following conditions below that currently affect you or that you have experienced in the past.

___ Fibromyalgia	___ Chronic Fatigue Syn	___ Sprains/Strains	___ Joint Dislocation
___ Tendonitis	___ Osteoarthritis	___ Rheumatoid Arthritis	___ Carpal Tunnel Syn
___ Bursitis		___ Broken Bones	
		___ Disk Problems	
___ Varicose Veins	___ Anemia		___ Low Blood Pressure
___ Stroke	___ TMJ Dysfunction	___ Heart Condition	___ Hypertension
___ Cancer/Tumor	___ Chemo/Radiation	___ Blood Clots/DVT	___ HIV/AIDS
___ Diabetes	___ Kidney Disease	___ Epilepsy/Seizures	
___ Numbness/Tingling	___ Whiplash		___ Headache
___ Dizziness	___ Sciatica	___ Anxiety/Panic Attacks	___ Asthma
		___ Insomnia	
___ Indigestion	___ Ulcers		___ Diarrhea
	___ Abdominal Pain	___ Gallstones	
___ Impetigo			___ Edema
___ Rashes	___ Dermatitis/Eczema	___ Psoriasis	___ Pneumonia
	___ Warts/Moles	___ Athletes Foot	___ Surgery

The a [illegible] ribe 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 canceled or missed appointments without 24 hours notice will be charged in full for the price of the missed session. I acknowledge that I have received the Client bill of Rights.

Signature: ____ Date:______________________

Client Name:________________________

Date:	Therapist notes: