

CLIENT INFORMATION

Name _____ Email _____
 Address _____ State _____ Zip _____
 Phone: Home (____) _____ Business (____) _____ Cell (____) _____
 Birth Month & Day _____ Occupation _____
 Recreational Activities _____ Hobbies _____
 Referred By _____

CLIENT CONDITION

Currently under a physician's care for what condition? _____
 If so, doctor's name _____
 Current Medications _____

Location of current pain _____ How long have you had this pain? _____ How often? _____
 Type of Pain: sharp dull throbbing numbness aching shooting
 burning tingling cramping stiffness swelling other
 Interferes with work sleep recreation daily routine other
 Painful moves sitting standing walking bending lying down other

MESSAGE HISTORY

Have you ever received a professional massage? Yes No
 What is your goal for today's session? _____

HEALTH HISTORY

For all the conditions that apply, please insert **P** for past history, and **C** for current:

- | | | |
|--|--|---|
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Blood Clots _____ | <input type="checkbox"/> Bursitis _____ |
| <input type="checkbox"/> Cancer, Tumors _____ | <input type="checkbox"/> Cardiovascular _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Disk Problems _____ | <input type="checkbox"/> Digestive _____ | <input type="checkbox"/> Headaches _____ |
| <input type="checkbox"/> High/Low Blood Pressure _____ | <input type="checkbox"/> Infection _____ | <input type="checkbox"/> Infectious Disease _____ |
| <input type="checkbox"/> Liver, Kidney _____ | <input type="checkbox"/> Neurological _____ | <input type="checkbox"/> Pinched Nerve _____ |
| <input type="checkbox"/> Phlebitis _____ | <input type="checkbox"/> Pregnancy (see reverse) _____ | <input type="checkbox"/> Respiratory _____ |
| <input type="checkbox"/> Rods, Plates _____ | <input type="checkbox"/> Skin Disorder _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Tendonitis _____ | <input type="checkbox"/> Tingling, numbness _____ | <input type="checkbox"/> Varicose Veins _____ |

Please list any medical conditions, surgeries, accidents, and bone, joint or muscle diseases or injuries not specified above. _____

AUTHORIZATION

I certify that the above information is correct to the best of my knowledge. I will not hold my Massage Therapist responsible for any errors or omissions that I may have made in the completion of this form, and I will inform my Massage Therapist of any changes in my health status.

I understand that Massage Therapy is designed to be a health aid and is not a substitute for a doctor's care. Information exchanged during Massage sessions is educational, and is to be used at my own discretion.

Client Signature _____

Date _____