CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

First Name: _____ M.I. ____ Last Name: _____

Address: _____City: _____ State: _____ Zip: _____

Phone (h): _____ (c): _____ Birth Date: ____ /____ /_____

Email Address: _____ Marital Status: _____

Male☐ Female☐ Referred by: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Do you Exercise? ___ If yes how? _____

How much water do you drink in a day? _____ Do you consider yourself stressed? _____

Is this your first Professional Massage? _____ if no, how frequently do you get a massage? _____

If you've had massage before what type of pressure would you prefer today? Light Light/medium Medium Medium/ Deep Deep

Are you allergic to any lotions or creams? _____

Would you like an eye pillow while you are on your back to keep the room dark? (circle one) Yes No

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

Are you aware of any tension holding spots in your body? _____ If yes, location(s) _____

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

Less than 5 years ago: _____

More than 5 years ago: _____

What kind of care did you receive for your accidents or injuries? _____

Do you feel you have recovered from these events? ____ Please explain: _____

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

If yes, Please explain: _____

_____

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

Are you currently receiving any other type of medical or therapeutic treatment? ____ Please explain: _____

Please list any medication (vitamins, herbs or pharmaceutical) taken now or at regular intervals. Include an explanation of what the medication is used to treat: _____

Are you currently under the care of a physician? _____ Whom? _____

Please list reason(s): _____

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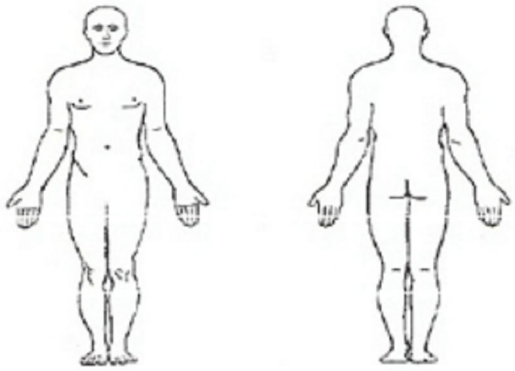
Please circle where you are experiencing pain or discomfort on the drawing below:



Are you currently experiencing any of the following conditions?

Flu or Cold ___ Inflammation ____ Fever ____ Infection ____ Contagious Disease____

Please check (✓) any of the following conditions below that currently affect you or that you have experienced in the last 5 years.

CIRCULATORY SYSTEM

__ Anemia
__ Hemophilia
__ Hypertension
__ Low Blood Pressure
__ Varicose Vein
__ Heart Condition
__ Blood Clots/Phlebitis
__ Diabetes
__ Swelling
__ Other_____

DIGESTIVE SYSTEM

__ Ulcers
__ Irritable Bowel Syndrome
__ Colitis
__ Gallstones
__ Hepatitis
__ Crohn's Disease
__ Diarrhea
__ Gas/Bloating
__ Indigestion
__ Bleeding
__ Constipation
__ Difficulty swallowing
__ Other_____

SKIN

__ Fungal Infections
__ Acne
__ Impetigo
__ Dermatitis/Eczema
__ Psoriasis
__ Open Wound or Sore
__ Rashes
__ Warts/Moles
__ Athletes Foot
__ Other_____

RESPIRATORY SYSTEM

__ Pneumonia
__ Sinusitis
__ Asthma
__ Trouble Breathing
__ Dizziness
__ Other_____

MUSCULOSKELETAL SYSTEM

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

NERVOUS SYSTEM

__ ALS
__ Multiple Sclerosis
__ Parkinson's Disease
__ Bell's Palsy
__ Neuritis
__ Spinal Cord Injury
__ Stroke
__ Seizure Disorders
__ Numbness/Tingling/Twitching
__ Other_____

OTHER

__ Insomnia
__ Sleep Apnea
__ Anxiety/Panic Attacks
__ Physical/Emotional Abuse
__ Substance Abuse
__ Grief Process
__ Cancer
__ Chronic Fatigue Syndrome
__ HIV/AIDS
__ Lupus
__ Kidney Disease
__ Bladder Infection
__ Postoperative Situation
__ Depression
__ Migraines
__ Frequent Headaches
__ Ear/nose/throat infection
__ Glaucoma
__ Visions problems
__ Other_____

The above information 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 and examination. I take full responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) may be charged in full for the price of the missed session.

Signature _____ Date: _____

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