

Today's Date _____

CLIENT INFORMATION

Name _____ M/F _____ DOB _____

Address _____ Home _____

City _____ State _____ Zip _____ Cell _____

Occupation/Employer _____

Physician _____ Phone _____

Email _____

Preferred name/Nickname _____ Preferred method of contact _____

Referred by _____

Emergency contact _____ Phone _____

Have you ever received a professional massage or bodywork session? Yes ___ No ___

If yes, how recently _____

What are your massage or bodywork goals? _____

Please list any areas of your body you do NOT wish to receive massage _____

Are you currently seeing a medical practitioner? Yes ___ No ___

If yes, please explain _____

List current medications, if any (including aspirin, ibuprofen, etc.) _____

Previous surgeries (include year and results) _____

Please review the list of conditions/symptoms on the reverse side and check all that apply to you. Feel free to provide details about anything that you think is important for me to know. Remember that this is for you.

MUSCULO-SKELETAL

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

CIRCULATORY

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

INFECTIOUS DISEASES

- ___ describe: _____
- ___ eating disorder _____
- _____

SKIN

- ___ allergies _____
- ___ rashes _____
- ___ athletes foot _____
- ___ warts _____
- ___ other _____

DIGESTIVE

- ___ constipation _____
- ___ gas/bloating _____
- ___ diverticulitis _____
- ___ irritable bowel syndrome _____
- ___ other _____

NERVOUS SYSTEM

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

REPRODUCTIVE

- ___ pregnant? stage? _____
- ___ PMS _____
- ___ other _____

OTHER

- ___ cancer/tumors _____
- ___ diabetes _____
- ___ nicotine/caffeine addiction _____
- ___ drug/alcohol addiction _____
- ___ depression _____
- _____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation, relief of muscular tension, increasing circulation or energy flow, and well-being of my body and mind. I agree to communicate with my practitioner any time I experience pain or discomfort during each session. I understand that massage/bodywork practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform skeletal adjustments. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all medical conditions that I am aware of and will update the massage/bodywork practitioner of any changes in my health status.

Signature _____ Date _____

Consent to Treatment of Minor/Dependent: By my signature below, I authorize _____ to administer massage/bodywork treatments to my child/dependent as they deem necessary.

Signature of Parent/Guardian _____ Date _____