Hand Prints
Massage Therapy

CLIENT HISTORY
Confidential

Your name: _____Your birthday(D/M/Y):_____

Mailing Address (Street/Box, Postal):_____

Daytime Phone Number: _____ Home Phone Number:_____

Occupation: _____Previous Massage Therapy? Yes ____ No ____

Please fill out the following as completely as possible to ensure effective and safe treatment.

Are you seeing any of the following regularly or in the past?
Chiropractor_____ Physiotherapist ____ Homeopath_____ Acupuncturist _____
Other ____ Please indicate _____

Please describe your concern today: _____

_____

What is your goal for subsequent treatments? _____

_____

Please list any exercise, hobbies, sports and other stress reduction activities: _____

_____

Do you sleep well? Yes _____ No _____

Please check any of the following which apply to you:

_____ Pregnant, due date_____
_____ Diabetic
_____ Past/Present Cancer
_____ Spine or disc conditions
_____ Contagious Disease
_____ Whiplash
_____ Achy/ painful joints; Arthritis
_____ High / Low blood pressure
_____ dry skin

Headaches Migraine/Tension
____ Constipation
____ Anxiety
____ Fatigue
____ Heart/ Circulatory Conditions
____ contact lenses
____ TMJ dysfunction
____ any brace support
____ allergies; specify_____

Please list any other medical conditions _____

If you indicated yes to headaches please describe them____

Please fill out Page 2……

_____

Do you find that stress affects you? Yes _____ No _____

If yes please describe any symptoms _____

If you have been in a Motor Vehicle or any other accident/trauma please

describe_____

Have you had any major surgeries? Yes _____ No _____

If so please explain _____

Indicate any medications you are taking_____

_____

Consent to Massage Therapy Treatment
I understand that the massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm, reduction of scar tissue and chronic pain and for the promotion of circulation, lymph activity and energy flow.
I understand that a Massage Therapist does not diagnose illness, disease or any other physical of mental disorder. It has been made very clear to me that massage therapy is not a substitute of medical examination and/or diagnosis and that it is recommended that I see a doctor for any physical ailment that I may have.
A massage therapist must be aware of existing physical conditions. Hence I have stated all my known medical conditions and take it upon myself to keep the Massage Therapist updated on my physical health.

Massage Therapists will not be required to compensate for patients' failure to arrive on time for their treatment. There will be up to a $90.00 surcharge for missed massage appointments or failure to cancel 24 hours prior to the appointment. Please try to arrive early for your appointment.

Print Name_____

Signature _____ Date _____

Thank you for taking the time to fill out your case history. I will be with you shortly.

Your Hand Prints' Massage Therapist (RMT)