Client Information & Health History

Name_____

Address_____

City_____ State_____ Zip Code_____

Phone Number_____ Birth Date_____

Email Address_____

Referred by_____

Mobile service provider for text reminders (optional):_____

Is this your first professional massage? Yes☐ No☐

If no, how frequently do you receive massage?_____

What other therapies have you tried?

_____

Are you under a doctor or other health practitioner's care? Yes☐ No☐

If yes, please give a brief description:

_____

_____

Please check any of the following conditions that apply to you:

- ☐ Headaches
- ☐ Asthma
- ☐ Smoking
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Heart disease
- ☐ Phlebitis
- ☐ Stroke
- ☐ Varicose veins
- ☐ Heart attack / Pace Maker
- ☐ Pregnancy
- ☐ Bruise easily
- ☐ Skin conditions
- ☐ Arthritis
- ☐ Painful menstruation
- ☐ Epilepsy
- ☐ Diabetes
- ☐ Sinus infection
- ☐ Alcohol use
- ☐ Drug use
- ☐ Insomnia
- ☐ Cancer
- ☐ Painful joints / Bursitis
- ☐ Fibromyalgia
- ☐ Edema
- ☐ Skin Diseases
- ☐ Rash / Skin Irritation
- ☐ Open wounds
- ☐ Nut Allergies

STEP ABOVE MASSAGE

Please describe any surgeries, hospitalizations, accidents or injuries you have had, and any open or healing wounds:

_____

_____

_____

Please list any medications you are currently taking: (specifically anti-inflammatory, pain killers, muscle relaxers, and blood thinners)

_____

_____

Describe the nature of the pain – is it local, does it radiate outward, is there a position of comfort, or restriction of movement?

_____

_____

When did the "problem" start?

_____

What has helped relieve the "problem"?

_____

What are your expectations for your session today?

_____

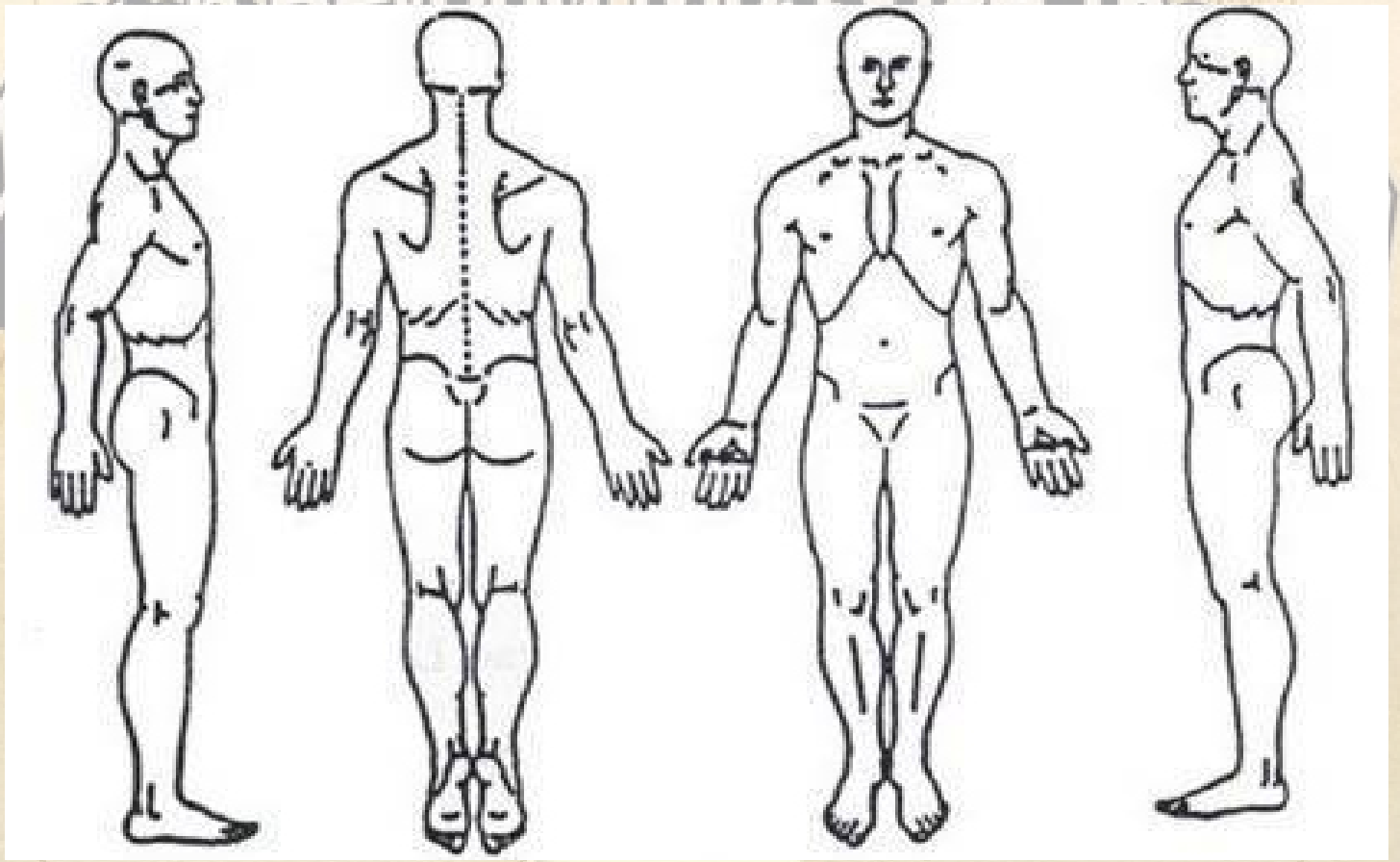
Other health conditions or comments:

_____

By signing this document, I, _____, understand that this is a confidential medical history and that all medical records and conversations with my therapist will remain private. Advice from the therapist is non-medical and does not replace seeing a doctor. I also understand that my therapist will only work within her scope of practice, that I have the right to ask my therapist not to massage any part of my body I am not comfortable having massaged, and that this massage is for the purposes of relaxation and the relief of stress and muscular tension. I give my consent for my therapist to treat me.

Signature_____ Date_____

Please circle areas on the diagram below that you feel need extra work. Cross out any areas you would like to be avoided.



Preferred Pressure (circle one): Light Medium Deep ???

Signature: _____