

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:

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



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 therapists will only work within their scope of practice, that I have the right to ask my therapists 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 _____

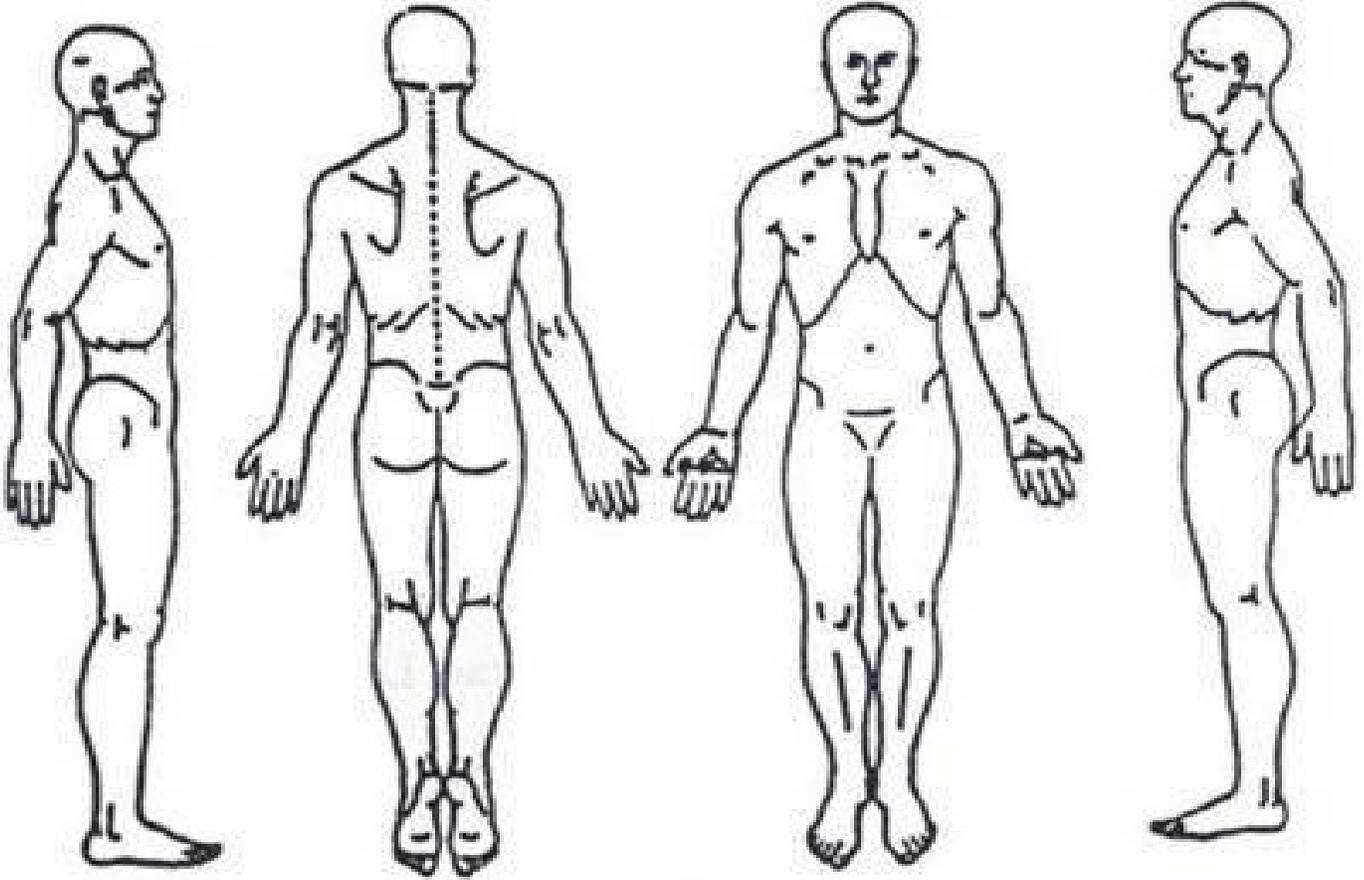




Please circle areas on the diagram below that you feel need extra work. Cross out any areas you would like to be avoided.

STEP ABOVE MASSAGE

STEP ABOVE MASSAGE



Preferred Pressure (circle one): Light Medium Deep

Signature: _____

STEP ABOVE MASSAGE



STEP ABOVE MASSAGE



STEP ABOVE MASSAGE



STEP ABOVE MASSAGE



STEP ABOVE MASSAGE

