



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: _____

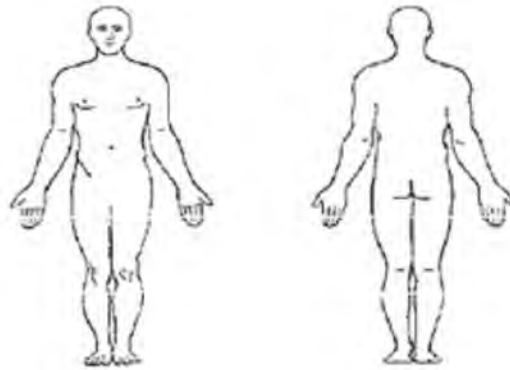
Are you currently receiving any other type of medical or therapeutic treatment? ___ Please explain: _____

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): _____

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 _____

- RESPIRATORY SYSTEM**
- Pneumonia
 - Sinusitis
 - Asthma
 - Trouble Breathing
 - Dizziness
 - Other _____

- NERVOUS SYSTEM**
- ALS
 - Multiple Sclerosis
 - Parkinson's Disease
 - Bell's Palsy
 - Neuritis
 - Spinal Cord Injury
 - Stroke
 - Seizure Disorders
 - Numbness/Tingling/Twitching
 - Other _____

- DIGESTIVE SYSTEM**
- Ulcers
 - Irritable Bowel Syndrome
 - Colitis
 - Gallstones
 - Hepatitis
 - Crohn's Disease
 - Diarrhea
 - Gas/Bloating
 - Indigestion
 - Bleeding
 - Constipation
 - Difficulty swallowing
 - Other _____

- MUSCULOSKELETAL SYSTEM**
- Fibromyalgia
 - Spasms/Cramps
 - Sprains/Strains
 - Osteoporosis
 - Postural Deviations
 - Gout
 - Osteoarthritis/Rheumatoid Arthritis
 - TMJ
 - Cysts
 - Bursitis
 - Plantar Fasciitis
 - 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 _____

- 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 _____

- SKIN**
- Fungal Infections
 - Acne
 - Impetigo
 - Dermatitis/Eczema
 - Psoriasis
 - Open Wound or Sore
 - Rashes
 - Warts/Moles
 - Athletes Foot
 - 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: _____