

CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

First Name: _____ M.I. _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone(h): _____ (w) _____ Date of Birth: _____

Employer: _____ Occupation: _____

Emergency contact: _____ Phone: _____ Relationship: _____

Referred by: _____ e-mail: _____

Is this your first professional massage? _____ If no, how frequently do you get a massage? _____

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 that you have recovered from these events? _____ Please explain: _____

Do you have any chronic, ongoing pain that you deal with on a regular basis? _____

Please explain: _____

Describe what activities cause this pain and/or make it worse: _____

Are you receiving any other type of medical treatment? _____ Please explain: _____

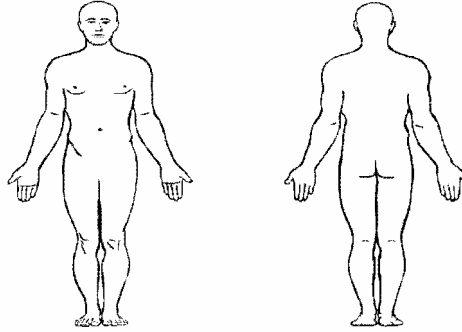
Please list any medication (vitamins, herbs or pharmaceutical) taken now or at regular intervals (include explanation of what medication is used to treat): _____

Are you currently under the care of a physician? _____ Whom? _____

Please list reason(s): _____

Are there any other health concerns you wish to discuss today? _____ If yes, please describe: _____

Please indicate where you experience pain 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.

MUSCULOSKELETAL

- 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
- Headache
- Leg Pain
- Arm Pain/Shoulder Pain
- Low Back Pain
- Mid Back Pain
- Hip Pain
- Other _____

RESPIRATORY

- Pneumonia
- Sinusitis
- Asthma
- Trouble Breathing
- Dizziness
- Other _____

CIRCULATORY

- Anemia
- Hemophilia
- Hypertension
- Low Blood Pressure
- Raynaud's Disease
- Varicose Veins
- Heart Condition
- Blood Clots/Phlebitis
- Diabetes
- Other _____

DIGESTIVE

- Ulcers
- Irritable Bowel Syndrome
- Colitis
- Gallstones
- Hepatitis
- Crohn's Disease
- Diarrhea
- Gas/Bloating
- Indigestion
- Other _____

SKIN

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

NERVOUS SYSTEM

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

OTHER

- Insomnia
- Anxiety/Panic Attacks
- PMS
- Grief Process
- Cancer
- Substance Abuse
- Pregnancy
- Chronic Fatigue
- HIV/AIDS
- Lupus
- Kidney Disease
- Bladder Infection
- Postoperative Situation
- Edema
- 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 or examination. I take 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: _____