CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

First Name: _____M.I. _____ Last Name: _____

Mailing Address: _____City: _____ State: _____ Zip: _____

Phone(h): _____ (w): _____ (c): _____

DOB: _____ Occupation: _____

Referred by: _____ Emergency Contact: _____ Phone: _____

e-mail_____ ☐ For Scheduling Purposes Only

Is this your first professional massage? **Y / N** How long since last massage? _____

What level of pressure do you prefer? Gentle Moderate Deep Depends on location/modality

Describe any surgeries, hospitalizations, accidents or injuries you have had:

_____

_____

Did you receive care for your accidents or injuries? _____

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

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

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 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 Fascitis
___ 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
___ DVT
___ 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 _____

- I am voluntarily wishing to experience a session(s) of therapeutic massage by Michelle Sanderson, CMT.
- I understand that massage therapists do not diagnose illness, prescribe medications or make spinal adjustments. I further understand that massage is not a substitute for medical care or treatment.
- I have alerted my therapist to any conditions I have which may affect the work and have disclosed all medications (herbal or pharmaceutical) that I am currently taking. I further agree to update my practitioner to any changes in my mental, emotional or physical health.
- I am seeking therapeutic massage of my own accord for the purposes that massage is intended. Such purposes include but are not limited to relaxation, mental wellness, relief of tension for sore muscles, improved circulation and/or improved range of motion.
- I understand and have had explained to me the procedure, benefits and contraindication for massage and the side-effects which may occur as a result of massage.
- Clients choosing to receive lymphatic drainage to breast tissue may withdraw consent and stop therapy at any time.

Signature:_____ Date:_____