Renewal Therapeutic Massage

Client Confidential Information & Health History

Date:_____

Full Name:_____

Nickname:_____

Date of Birth: _____

Address:_____

_____

_____ ____ _____
City State Zipcode

Phone:

Cell: (_____)_____

Home: (_____)_____

Email: _____
Required for Appointment Confirmation

Occupation:_____

Employer:_____

Marital Status:_____

Referred by: _____

Emergency Contact:_____

Emergency Phone:_____

Current Physician(s):

Name:_____

Specialty:_____

Pain Scale Today - Circle best Answer

None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Worst

Massage Experience:

Have you had a professional massage before?

YES NO

What type of Massage?

THERAPEUTIC RELAXATION

How long since your last massage?

WEEKS MONTH YEAR TOO LONG

Reason for initial visit:

_____

_____

_____

Do you exercise regularly and/or participate in any sports? YES NO

What kind & frequency?

_____

Do you perform any repetitive movement in your work, sports, or hobby? YES NO If yes explain:_____

_____

Are you currently experiencing tension, stiffness, discomfort, or pain ? YES NO If yes explain:

_____

_____

Do you have any recent, old or chronic injuries, surgeries or areas of frequent inflammation? Please explain:

_____

_____

Do you have Sensitive Skin? YES NO

Known Irritants:_____

Known Allergies:_____

List any Medications you are currently taking and for what?

_____

_____

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Health History

Musculoskeletal
- ❑ Bone or Joint Disease
- ❑ Tendonitis or Bursitis _____
- ❑ Arthritis or Gout _____
- ❑ Jaw Pain (TMJ)
- ❑ Lupus
- ❑ Spinal Problems_____
- ❑ Migraines or Headaches
- ❑ Osteoporosis

Circulatory
- ❑ Heart Condition
- ❑ Phlebitis or Varicose Veins
- ❑ Thrombosis or Embolism
- ❑ Blood Clots
- ❑ High or Low Blood Pressure
- ❑ Lymphedema

Respiratory
- ❑ Breathing Difficulty or asthma
- ❑ Emphysema
- ❑ Allergies_____
- ❑ Sinus Problems

Nervous System
- ❑ Shingles
- ❑ Numbness or Tingling
- ❑ Pinched Nerve
- ❑ Chronic Pain
- ❑ Paralysis
- ❑ Multiple Sclerosis
- ❑ Parkinson's Disease

Reproductive
- ❑ Pregnant Stage_____
- ❑ Ovarian/Menstrual Problems
- ❑ Prostate

Skin
- ❑ Allergies _____
- ❑ Rashes
- ❑ Cosmetic Surgery
- ❑ Athlete's Foot
- ❑ Herpes/Cold Sores
- ❑ Thyroid Hyper/ Hypo Hashimoto's

Digestive
- ❑ Irritable Bowel Syndrome
- ❑ Crohn's Disease
- ❑ Bladder/ Kidney Ailment
- ❑ Colitis
- ❑ Ulcers

Psychological
- ❑ Anxiety/ Stress Syndrome
- ❑ Depression
- ❑ PTSD
- ❑ Other_____

Other
- ❑ Cancer/ Tumors_____
- ❑ Diabetes
- ❑ HIV/ AIDS
- ❑ Hepatitis A, B or C
- ❑ Drug/ Alcohol / Tobacco
- ❑ Contact Lenses
- ❑ Dentures
- ❑ Hearing Aids

Any other medical condition(s) not listed:_____
_____

Explanations:_____
_____
_____

The above information is true and accurate to my knowledge. I understand that massage therapists do not diagnose disease, prescribe medication, or manipulate bones with force. 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 agree not to hold my practitioner liable should I fail to notify my practitioner of any changes. I understand that the massage I receive is provided with the basic purpose of relaxation and the treatment of muscular tension. If I experience any pain or discomfort during the session I will immediately inform the massage therapist so that the pressure/ strokes can be adjusted to my level of comfort.
I also understand that cancelled or missed appointments without 24 hrs prior notice (medical emergencies excluded) will be charged the full price of the missed session.
Any inappropriate conduct from you as a client while on the premises or during communications with your massage therapist may result in termination of services permanently. You will be responsible to pay for the full amount of the session. Any packages previously purchased would also be forfeit.

Signature_____ Date_____