

Health Information

Client Information

Client Name: _____ Date: _____

Date of Birth: _____ Active/Retired Military: (Y/N)

Address: _____
Street City/State Zip

Phone: _____ Email: _____

Emergency Contact: _____ Phone: _____

Referred by: _____

Health Care Provider Name: _____ Phone: _____

Employment Information

Employed: (Y/N/Retired): _____ Current/Former Occupation: _____

Are You A Student: (Y/N) _____

Repetitive Actions Performed at Work/School: _____

Sit at a Computer: (Y/N) _____ If So, Duration: _____ # Days/Week: _____

Drive To/From Work: (Y/N) _____ If So, Distance: _____ # Days/Week: _____

Massage Information

Have you received professional bodywork before: (Y/N) _____ How Recently: _____

Why Do You Seek Massage: (Treatment/Relaxation/Injury) _____

What Are Your Goals/Expectations for Receiving Bodywork? _____

Body Areas to Avoid: _____ Do You Prefer Lotion/Oil/No Preference: _____

Health Information

How do you Feel Today? _____

What are Your Current Symptoms (Location, Intensity): _____

Are these Chronic Areas of Complaint: (Y/N) _____ If Yes, How Often: _____

How Do You Reduce Your Symptoms:

Symptoms Interfere With Activities of Daily Living (ie. sleep, exercise, work, childcare?) (Y/N): _____

If Yes, Explain: _____

Please List Injuries/Accidents (Area/Date): _____

Health Information, Continued

Please List Surgeries (Area/Date): _____

Are You Receiving Further Medical Treatment for Your Current Symptoms: (Y/N) _____

If Yes, Who and How Often: _____

List Medications You Currently Take: _____

Are You Wearing: (Y/N) Contacts: _____ Dentures: _____ Hairpiece: _____ Pregnant: _____

Please answer the following honestly as massage may not be indicated(safe) for these conditions

Circle any of the following health conditions that you currently have (If you are unsure, please ask):

Blood Clots Infections Congestive Heart Failure Pitted Edema Contagious Disease

Indicate Conditions You Have or Have Had in the Past. Explain Treatment (ie. medication, surgery, PT.OT,DC)

- | | | |
|---------|------|--|
| Current | Past | Muscle or Joint Pain/Stiffness |
| Current | Past | Numbness or Tingling (Where/When) |
| Current | Past | Swelling (Where/When) |
| Current | Past | Bruise Easily |
| Current | Past | Sensitive to Touch/Pressure (Where/When) |
| Current | Past | High/Low Blood Pressure |
| Current | Past | Stroke |
| Current | Past | Heart Attack |
| Current | Past | Shortness of Breath, Asthma |
| Current | Past | Cancer (Location) |
| Current | Past | Neurological (eg. MS, Parkinson's) |
| Current | Past | Epilepsy, Seizures |
| Current | Past | Headaches, Migraines |
| Current | Past | Dizziness, Ringing in the Ears |
| Current | Past | Digestive Conditions (eg. Chron's, IBS) |
| Current | Past | Kidney Disease, Infection |
| Current | Past | Arthritis (Type/Location) |
| Current | Past | Osteoporosis, Degenerative Spine/Disc, Bulging Disc (Location) |
| Current | Past | Scoliosis |
| Current | Past | Broken Bones |
| Current | Past | Allergies (Type/Areas Affected) |
| Current | Past | Diabetes |
| Current | Past | Endocrine/Thyroid Conditions |
| Current | Past | Depression/Anxiety |
| Current | Past | Memory Loss, Confusion, Easily Overwhelmed |

Comments:

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware.

I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

I understand that any illicit or sexually suggestive remarks or advances made by me will not be tolerated and result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. I also understand that the use of draping during the massage session is non-negotiable. Understand all of this, I give my consent to receive care.

Client Signature: _____ **Date:** _____

Parent or Guardian Signature (in case of a minor): _____ **Date:** _____