Alive and Well Therapeutic Massage
Confidential Client Information and Health History Form

Name: _____ Today's date: _____

Address: _____ City/State/Zip _____

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

Emergency Contact and Phone Number: _____

E-mail address: _____

For appointment confirmation, contact me by: □ Home □ Work □ Cell □ E-mail

Please □ do □ do NOT add me to your e-mail list for notices of events and specials.

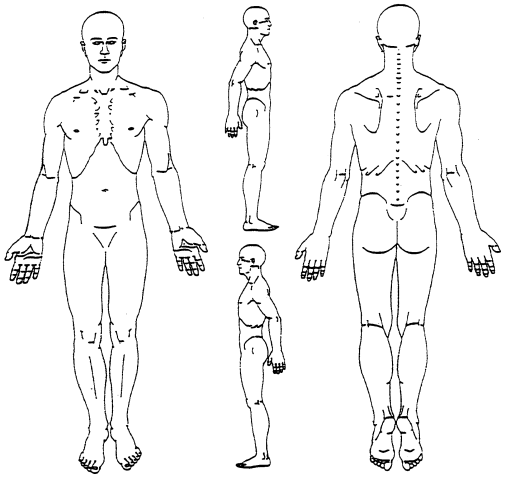
Optional information for promotional purposes:

Birth Month & Day: _____ Referred By: _____

1. Is this your first professional massage? *Yes No* How frequently do you get a massage? _____
2. List your occupation and any hobbies that might affect your condition: _____

   _____
3. In what types of exercise do you engage regularly? _____
4. What are your goals for your massage treatment? _____
5. Circle the number *(1 low/5 high)* that best describes your current level of stress: *1 2 3 4 5*
6. Circle the number *(1 low/5 high)* that best describes your current level of health: *1 2 3 4 5*
7. Describe how stress is affecting your health and wellness or indicate N/A: _____

   _____
8. Indicate on the diagram the areas in which you are having problems. Then check all descriptions that apply:



Pain:
□ Dull or Achy
□ Sharp or Shooting
□ Burning or Tingling
□ Pins and Needles
□ Numbness
□ Sudden Weakness

Conditions:
□ Bruising
□ Swelling
□ Rash
□ Spasm
□ Stiffness
□ Decreased Range of Motion

What other concerns do you have? _____

_____

_____

_____

_____

I do NOT want the following areas worked on during my massage.
(You will be fully draped at all times except for the specific area being worked. Please discuss any concerns with your therapist.)

Face Head Neck Shoulders Arms Hands Back Gluts (can work through draping) Legs - upper / lower Feet

Client Health History

Since under some conditions massage should be avoided or modified, it is important to get a brief understanding of any past or current health issues before working with a new client. Thank you for taking time to complete this section.

1. Are you seeking massage treatment to deal with an ongoing condition or problem? *Yes* *No*

2. If yes, are you currently under the care of a health practitioner (physician, chiropractor, psychologist, physical therapist) for this condition? *Yes* *No* Describe: _____

   _____

3. Are you currently experiencing any of the following? (check all that apply and add comments if applicable)

   □ Allergies to perfumes / lotions
   □ Symptoms of cold / other illness
   □ Arthritis
   □ Athlete's foot
   □ Burns
   □ Cuts / Sores
   □ Eczema
   □ Fractures
   □ Acute injury
   □ Headache / Migrane
   □ Impetigo
   □ Joint / Back problems
   □ Muscle Strain / Sprain
   □ Pregnancy
   □ Varicose Veins
   □ Wearing contacts
   □ Wearing hearing aids
   □ Wearing dentures

   _____

   _____

   _____

4. Have you ever experienced any of the following? (check all that apply and add comments if applicable)

   □ Allergies
   □ Arthritis
   □ Cancer or tumors
   □ Circulatory problems
   □ Diabetes
   □ Epilepsy
   □ Fractures
   □ Heart Disease
   □ High / Low blood pressure
   □ Joint / Back problems
   □ Kidney disease
   □ Lung disease
   □ Stroke
   □ Thyroid disorder

   _____

   _____

   _____

Liability Waiver

I understand that the massage I receive is provided for the basic purpose of relaxation and relief from muscle tension and any accompanying pain and stiffness. If I experience any pain or discomfort during the session I will immediately inform the therapist. I understand that the massage therapist does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor provide spinal manipulations as part of massage therapy. I further understand that massage therapy is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have.

Because massage 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 on any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____