Renewal Therapeutic Massage

Confidential Information & Health History

Date: ____________________ Where did you hear about us?_________________________________

Full Name:__________________________________ Date Of Birth _____/______/__________

Address:____

City:_____________________________ State:________ Zip code:_________________

Phone: (home)______________________ email:____

(mobile)______________________ Marital Status:____________________________________

Occupation:_____________________________ Employer:___________________________________

Is this your first professional Massage? Circle Yes No

If no how frequently do you get a massage? Circle weekly monthly quarterly yearly Not often enough

Do you have any specific issues you would like to focus on today? ___________________________________

____

Are you currently under the care of a physician? Yes No Whom?___________________________________

Have you had any accidents, injuries or surgeries in the past 5 years? Yes No If yes please describe below:

____

____

What is your pain level today on a scale of 0 being no pain and 10 being excruciating ? Please circle:

0 1 2 3 4 5 6 7 8 9 10

Current Health

Do you exercise regularly and/or participate in any sports? Yes No

If yes what kind of exercise/sports____

Do you perform any repetitive movement in your work, sports or hobby? Yes No

If yes describe____

Do you sit for long hours at a workstation, computer or driving? Yes No

If yes specify____

Do you experience stress in your work, family or other aspect in your life? Yes No

Are you experiencing tension, stiffness, discomfort or pain? Yes No

If yes describe____

Have you recently had an injury, surgery, or areas of inflammation? Yes No

If yes describe____

Do you have sensitive skin? Yes No

Do you have any allergies to oils, lotions, or ointments? Yes No Explain________________________

List any medications you are currently taking:____

____

List any known allergies ____

Are you currently experiencing any of these symptoms or conditions? Please check those that apply to you:

Musculoskeletal

___ Bone or joint disease
___ Tendonitis/Bursitis
___ Arthritis/Gout
___ Jaw Pain (TMJ)
___ Lupus
___ Spinal Problems
___ Migraines/Headaches
___ Osteoporosis

Circulatory

___ Heart Condition
___ Phlebitis/Varicose Veins
___ Blood Clots
___ High/Low Blood Pressure
___ Lymphedema
___ Thrombosis/Embolism

Respiratory

___ Breathing Difficulty/Asthma
___ Emphysema
___ Allergies, specify:___________
___ Sinus Problems

Nervous System

___ Shingles
___ Numbness/Tingling
___ Pinched Nerve
___ Chronic Pain
___ Paralysis
___ Multiple Sclerosis
___ Parkinson's Disease

Reproductive

___ Pregnant, stage ________________
___ Ovarian/Menstrual Problems
___ Prostate

Skin

___ Allergies, specify:_____________
___ Rashes
___ Cosmetic Surgery
___ Athlete's Foot
___ Herpes/Cold Sores

Digestive

___ Irritable Bowel Syndrome
___ Bladder/KidneyAilment
___ Colitis
___ Crohn's Disease
___ Ulcers

Psychological

___ Anxiety/Stress Syndrome
___ Depression

Other

___ Cancer/Tumors
___ Diabetes
___ Drug/Alcohol/Tobacco Use
___ Contact Lenses
___ Dentures
___ Hearing Aids

Any other medical condition(s) not listed:

Please explain any of the conditions that you have marked above :

____
____
____
____

The above information is true and accurate to my knowledge. I understand that massage therapists do not diagnose disease, prescribe medication, 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 agree to not hold my practitioner liable should I fail to do so. I understand that the massage I receive is provided with the basic purpose of relaxation and the relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the 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 notice (medical emergencies excluded) will be charged in full for the price of missed session if it cannot be rebooked.

Client Signature_____________________________________ Date_________________________