Health Information

Client Contact Information

Client Name: ______________________________ Date: _________________

Date of Birth: ______________ Gender: M F

Address: ____

Phone: _______________________ Email: ____________________________________

Emergency Contact: __________________________ Phone: _____________________

Physician/Health Provider Name:__________________________ Phone: ______________

Where did you hear about us? Check all that apply:

☐ Groupon ☐ Facebook ☐ Yelp ☐ Other: ______________________________

Massage Information

Have you ever received massage / bodywork before? Yes ☐ No ☐

How recently? ____________________________________

What types of massage / bodywork do you prefer?

____

What are your goals / expected outcomes for receiving massage / bodywork?

____

____

Please list any needs I should prepare for:

____

Do you have any of the following symptoms? Describe how they affect your daily living (i.e. sleep, exercise, work, childcare, etc).

☐ Stress ____

☐ Pain ____

☐ Stiffness ____

☐ Numbness/tingling ____

☐ Swelling ____

☐ Other ____

What medications are you currently taking?

____

____

Are you currently pregnant? Yes ☐ No ☐

Do you have cancer? Yes ☐ No ☐

Health Information

Health History

Have you experienced any of the following? Check all that apply and explain:

- ☐ Allergies ______________________________
- ☐ Arthritis ______________________________
- ☐ Blood clots ______________________________
- ☐ Blood pressure conditions ______________________________
- ☐ Chronic pain ______________________________
- ☐ Diabetes ______________________________
- ☐ Fibromyalgia ______________________________
- ☐ Headaches ______________________________
- ☐ Heat sensitivity ______________________________
- ☐ Heart problems ______________________________
- ☐ History of Strokes ______________________________
- ☐ Infections ______________________________
- ☐ Injuries ______________________________
- ☐ Insomnia ______________________________
- ☐ Immune system deficiencies ______________________________
- ☐ Lupus ______________________________
- ☐ Skin conditions ______________________________
- ☐ Surgeries ______________________________
- ☐ Varicose veins ______________________________
- ☐ Other ______________________________

Areas of stress or pain: (select all that apply and the pain level associated with it)

☐ Neck

0 1 2 3 4 5 6 7 8 9 10

No Pain — High Pain

☐ Back

0 1 2 3 4 5 6 7 8 9 10

No Pain — High Pain

☐ Legs

0 1 2 3 4 5 6 7 8 9 10

No Pain — High Pain

☐ Shoulders

0 1 2 3 4 5 6 7 8 9 10

No Pain — High Pain

☐ Arms

0 1 2 3 4 5 6 7 8 9 10

No Pain — High Pain

☐ Other __________________

0 1 2 3 4 5 6 7 8 9 10

No Pain — High Pain

Circle any areas on which you are uncomfortable having therapeutic massage:

Abdomen   Face   Feet   Scalp   Gluteal region   Pectoral muscles

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, diagnoses, or treatment and that I should see a physician, chiropractor, 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 also understand that any illicit or sexual suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for the payment of the scheduled appointment. Understanding all this, I give my consent to receive care.

Client Signature: ______________________________ Date: ______________