

MESSAGE CLIENT HEALTH INFORMATION

This following information is requested to more accurately assess and fulfill your individual massage needs.
Please be assured that all information will be kept strictly confidential.

Personal Information

Name _____ Phone (day) _____
Address _____ Phone (eve) _____
City/State/Zip _____ Birthdate _____
E-mail Address _____ Occupation _____
Referred by _____ Emergency Contact _____
Phone # _____

Massage History/Treatment Information

Have you ever received massage therapy? Yes (Frequency: _____) No
Why do you need a massage today? Stress Reduction/Relaxation Pain Relief/Muscular Soreness
 General Well-being Part of Holistic Health Plan Other _____

Please indicate any areas of your body you **do not** want massaged: _____

Please indicate the level of pressure you prefer: Light Medium Deep

Health History

Are you currently under the care of a medical professional? Yes, please explain _____ No
List any medications you are taking (including Ibuprofen/Tylenol): _____
Have you had any accidents (auto/sports related)? Yes, please explain _____ No
Have you had any surgeries? Yes, please explain _____ No
Describe the type and frequency of exercise you do: _____

Please mark each symptom/health related condition that applies:

Musculo-Skeletal/Nervous System

Spasms/Cramps Tendonitis Bursitis Broken/Fractured Bones Arthritis
 Sprains/Strains TMJ/Jaw Pain Chronic Pain Whiplash Headaches/Migraines
 Numbness/Tingling Seizures Chronic Pain Other _____

Circulatory

Heart Condition Diabetes Varicose Veins Blood Clots High/Low Blood Pressure

Diseases

Herpes/Shingles HIV/Aids Lupus Cancer/Tumors Addictions

Respiratory/Skin/Digestive

Allergies (Hayfever/Sinus) Allergies (Oils/Perfumes) Rashes/Cuts/Burns Other _____
 Constipation Gastric Reflux Ulcers Irritable Bowel Syndrome Other _____

Reproductive

Pregnant PMS Other _____

Client Agreement

As a client, I understand that massage therapy is not a replacement for medical care and that no diagnosis will be made. I freely give my permission for the therapy received and I agree to hold _____ harmless regardless of outcome. I understand that payment is due at time of service unless prior arrangements have been made and that I will be charged half-price for any missed appointments unless 24 hours notice is given. Exceptions will be made for emergencies.

Client Signature

Date