Client Information & Health History

Name_____

Address_____

City_____ State_____ Zip Code_____

Phone Number_____ Birth Date_____

Email Address_____

Referred by_____

Is this your first professional massage? Yes No

If no, how frequently do you receive massage?_____

What other therapies have you tried?

_____

Are you under a doctor or other health practitioner's care? Yes No

If yes, please give a brief description:

_____

_____

Please check any of the following conditions that apply to you:

- □ Alcohol use
- □ Arthritis
- □ Asthma
- □ Bruise easily / Current Bruises
- □ Cancer / Tumors
- □ Diabetes
- □ Drug use
- □ Edema
- □ Epilepsy
- □ Fever
- □ Fibromyalgia
- □ Fractures
- □ Headaches
- □ Heart attack / Pace maker
- □ Heart disease
- □ High blood pressure
- □ Illness / Disease
- □ Insomnia
- □ Localized Infections
- □ Low blood pressure
- □ Medications
- □ Open Wounds
- □ Pacemaker
- □ Painful joints / Bursitis
- □ Painful menstruation
- □ Phlebitis / Thrombosis
- □ Poor circulation
- □ Pregnancy _____months
- □ Sinus infection
- □ Skin Irritation / Rash
- □ Skin conditions / Skin Diseases
- □ Smoking
- □ Stroke
- □ Swelling
- □ TMJ
- □ Varicose veins
- □ **Nut Allergies**
- □ **Other Allergies**

Please describe any surgeries, hospitalizations, accidents or injuries you have had, and any open or healing wounds:

_____

_____

_____

Please list any medications you are currently taking: (specifically pain killers, anti-inflammatory, blood thinners, and muscle relaxers)

_____

_____

Describe the nature of the pain – is it local, does it radiate outward, is there a position of comfort, or restriction of movement?

_____

_____

When did to "problem" start?

_____

What has helped relieve the "problem"?

_____

What are your expectations for your session today?

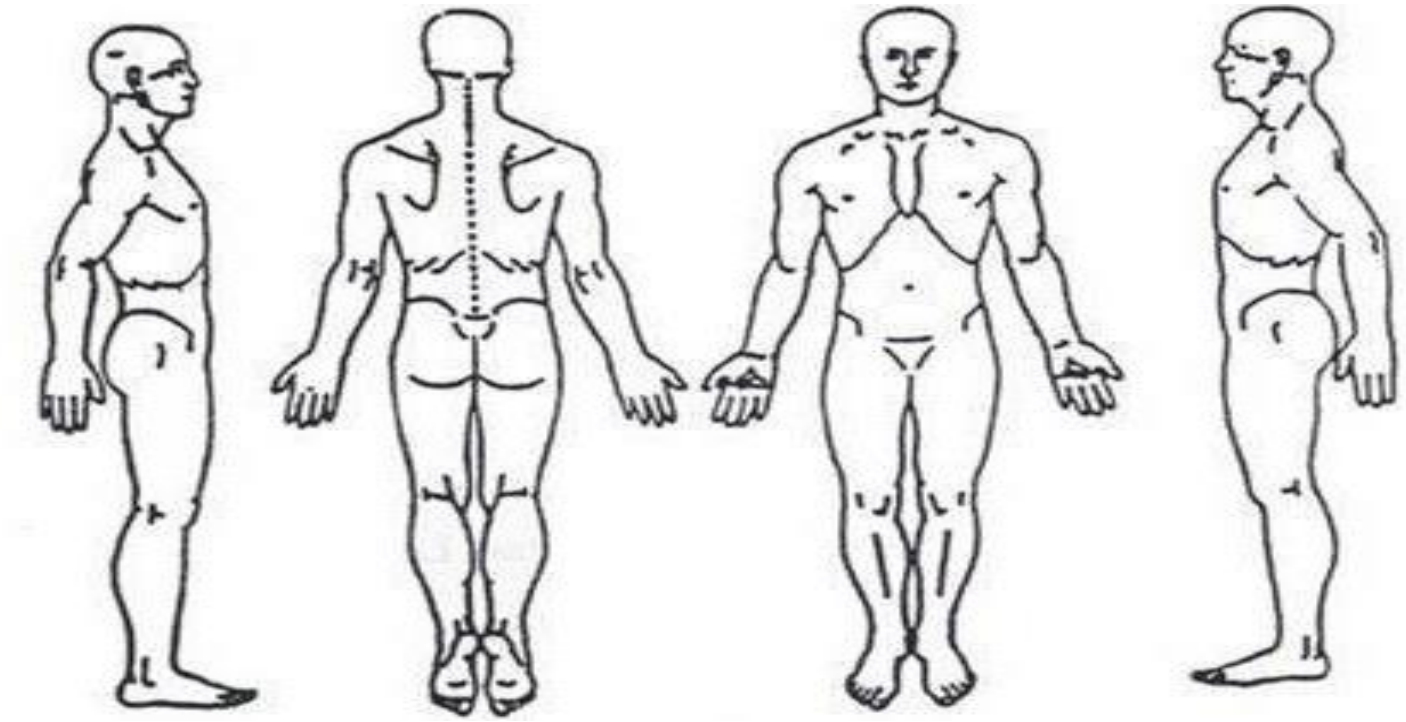
_____

Other health conditions or comments:

_____

Are you wearing any face or eye makeup? Yes No

Please circle areas on the diagram below that you feel need extra work. Cross out any areas you would like to be avoided.



Preferred Pressure (circle one): **Light** **Medium** **Deep** **???**

By signing this document, I, _____, understand that this is a confidential medical history and that all medical records and conversations with my therapist will remain private. Advice from the therapist is non-medical and does not replace seeing a doctor. I also understand that my therapist will only work within her scope of practice, that I have the right to ask my therapist not to massage any part of my body I am not comfortable having massaged, and that this massage is for the purposes of relaxation and the relief of stress and muscular tension. I give my consent for my therapist to treat me. Payment is confirmation of satisfactory service.

Signature_____ Date_____