

**Client Information**

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Email \_\_\_\_\_ Phone \_\_\_\_\_

(please circle which is your preferred means of contact for appointment reminders, etc)

Occupation \_\_\_\_\_

Emergency Contact (name and contact info) \_\_\_\_\_

**Health History**

Are you currently under the care of a health care practitioner? \_\_\_\_\_

If so, please specify: \_\_\_\_\_

List current medications and the purpose of each: \_\_\_\_\_

Do you currently have a fever or suffer from another contagious illness? \_\_\_\_\_

**Work and Leisure Activities**

Do you exercise regularly? \_\_\_\_\_

Type and frequency of exercise? \_\_\_\_\_

How long is your commute to work? \_\_\_\_\_

Do you work long hours in front of a computer? \_\_\_\_\_

List any repetitive activities that you do regularly (carrying a purse, texting, driving with one arm, crossing your legs, lifting, etc). \_\_\_\_\_

I understand the massage I receive is provided for the purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will inform the practitioner so that the pressure may be adjusted to my level of comfort. I affirm that I have stated all my known medical conditions to the best of my ability and agree to update my massage practitioner if there are any changes in my medical profile.

Client Signature \_\_\_\_\_

Parent/Guardian Signature (if minor) \_\_\_\_\_

Please indicate which of the following you are currently experiencing. If you have experienced something in the past, please indicate the approximate date.

**Musculoskeletal**

- Spine or Disc Problems
- Tendonitis/Bursitis
- Arthritis
- TMJ
- Muscle Strain/Sprain/Cramping/Weakness
- Osteoporosis
- Carpal Tunnel
- Other: \_\_\_\_\_

**Skin**

- Allergy (specify) \_\_\_\_\_
- Rash
- Fungal Infection (athlete's foot, ringworm, etc)
- Psoriasis/Eczema
- Other

**Nerve**

- Seizures
- Pinched Nerve
- Numbness/Tingling

**Other**

- Cancer/Tumors
- Migraines/Headaches
- Thyroid Disease
- Sleep Disorders/Fatigue
- Chronic Pain (specify) \_\_\_\_\_
- Recent Injury (specify) \_\_\_\_\_
- Recent Surgery (specify) \_\_\_\_\_
- Reduced Range of Motion (specify) \_\_\_\_\_
- Autoimmune Disease (specify) \_\_\_\_\_

**Circulatory**

- Heart Condition
- Phlebitis/Varicose Veins
- Thrombosis/Embolism
- High/Low Blood Pressure
- Lymphedema
- Other: \_\_\_\_\_

**Respiratory**

- Asthma
- Sinus Problems
- Allergy (specify) \_\_\_\_\_
- Other: \_\_\_\_\_

**Reproductive**

- Pregnant (trimester) \_\_\_\_\_
- Other

- Diabetes
- Depression/Anxiety
- Contact Lenses
- Lyme