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:_____

Circulatory

___Heart Condition

___Phlebitis/Varicose Veins

___Thrombosis/Embolism

___High/Low Blood Pressure

___Lymphedema

___Other:_____

Skin

___Allergy (specify)_____

___Rash

___Fungal Infection (athlete's foot, ringworm, etc)

___Psoriasis/Eczema

___Other

Respiratory

___Asthma

___Sinus Problems

___Allergy (specify)_____

___Other:_____

Nerve

___Seizures

___Pinched Nerve

___Numbness/Tingling

Reproductive

___Pregnant (trimester)_____

___Other

Other

___Cancer/Tumors

___Migraines/Headaches

___Thyroid Disease

___Sleep Disorders/Fatigue

___Diabetes

___Depression/Anxiety

___Contact Lenses

___Lyme

___Chronic Pain (specify)_____

___Recent Injury (specify)_____

___Recent Surgery (specify)_____

___Reduced Range of Motion (specify)_____

___Autoimmune Disease (specify)_____