CONFIDENTIAL CLIENT HISTORY

In order to maximize the effectiveness and safety of your massage session, please take the time to carefully fill out this form. This information will be treated confidentially. Thank you.

Name: _____ Date: _____

Address: _____

City: _____ ST: _____ Zip: _____

☐ Ok to Mail ☐ Do not mail

Home Phone: _____ Cell Phone: _____

☐ Ok to call home ☐ Do not call home ☐ Ok to call cell ☐ Do not call cell

E-mail address: _____

☐ Ok to e-mail ☐ Do not e-mail

Birth Date: _____ Age: _____ Referred by: _____

Reason(s) for wanting a massage:

☐ General relaxation / stress reduction ☐ Pain relief

☐ Help with specific injury or condition ☐ Aid in recovery from activity

☐ Other, please list: _____

Date of last professional massage: _____ Frequency: _____

Are there any areas of your body which you feel need particular attention: Yes / No

If Yes, which ones? _____

Are there any areas of your body you prefer NOT to have massaged: Yes / No

If Yes, which ones? _____

Do you wear contacts? Yes / No

Are you pregnant? Yes / No / I am Male

Are you taking any prescription or over the counter medication? Yes / No

If yes, please list medications: _____

Is your life stressful? _____ Please describe: _____

_____

Please list any illnesses, injuries and surgeries:

- Illnesses: _____
- Injuries: _____
- Surgeries: _____

Do you have ANY history of the following? Please check if "Yes". If no, leave blank.

Musculoskeletal:
_____ Bone or joint disease
_____ Arthritis
_____ Sprains / strains
_____ Low back pain
_____ Mid / Upper back pain
_____ Hip / Leg pain
_____ Neck pain
_____ Shoulder / Arm pain
_____ Headaches
_____ Jaw pain / clicking / popping
_____ Clenching or grinding teeth
_____ Spasms / cramps
_____ Spinal curvature
_____ Fibromyalgia
_____ Other: _____

Digestive:
_____ Constipation
_____ Gas / Bloating
_____ Hiatal hernia
_____ Other: _____

Respiratory / Circulatory:
_____ High Blood Pressure
_____ Breathing difficulties
_____ Varicose veins
_____ Other cardiovascular problems
_____ Other: _____

Skin:
_____ Rashes
_____ Bruise easily
_____ Sensitive skin
_____ Hives / Allergies
_____ Other: _____

Neurological:
_____ Herpes / Shingles
_____ Numbness / Tingling
_____ Chronic pain
_____ Dizziness (any cause)
_____ Other: _____

Genitourinary:
_____ Kidney infections
_____ Kidney stones
_____ Prostate problems
_____ Other: _____

For Women only:
_____ Painful menstruation
_____ Yeast infections
_____ Breasts lumps / masses
_____ Urinary track infections
_____ Other: _____

Other:
_____ Allergies (any)
_____ Sinus problems
_____ Cancer / tumors
_____ Fatigue
_____ Difficulty sleeping
_____ Diabetes
_____ Drug / Alcohol addiction
_____ Other: _____

Infectious Diseases:
_____ Disease name(s) _____
_____

Nicotine / Caffeine use: _____

PLEASE SIGN BELOW:

- I understand that this massage experience is for relaxation and wellness purposes.
- I understand that massage therapists do not diagnose illness, disease or any physical and/or mental disorders, nor do they prescribe medical or chiropractic treatment or pharmaceuticals. It is in no way intended to be a replacement for traditional medical care.
- I understand that it is my responsibility to inform the Therapist of any medical issues that may make me unsuitable for receiving Massage Therapy and it is my responsibility to inform the Therapist of any discomfort during the treatment.
- I have stated all medical conditions of which I am aware and will update the therapist of any changes in my health status.
- In accepting that responsibility I release the Therapist from any liability for discomfort I may experience as a result of receiving Massage Therapy.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____