Client Information

Personal Information

Name: _____ Date of Visit: _____

Address: _____ City _____ State/Zip: _____

Home Phone: _____ Work Phone: _____ e-mail _____

Date of Birth: _____ Sex (circle one) M F Referred by: _____

Emergency Contact: _____ Phone (Day) _____ (Evening) _____

What would you like to achieve in your massage sessions? _____

_____

Previous Bodywork/Exercise Information

Have you had professional massage therapy or bodywork before? Yes ☐ No ☐ If yes, where and what type? _____

_____

How often do you receive massage therapy or bodywork? _____

Do you exercise regularly? Yes ☐ No ☐ Type? _____ How often? _____

Do you stretch regularly? Yes ☐ No ☐ Type? _____ How often? _____

Stress Level

What is your current stress level? (Circle one number) Low 1 2 3 4 5 High

Do you feel that your stress level is positive ☐ negative ☐ both ☐ ?

Do you feel anxious often ☐ sometimes ☐ seldom ☐? Explain: _____

_____

Do you feel depressed often ☐ sometimes ☐ seldom ☐? Explain: _____

_____

How many hours do you sleep on average? _____

Do you wake feeling rested ☐ tired ☐ other ☐? Explain: _____

_____

Specific Complaints or Pain Issues

What complaint or pain brought you to the clinic? _____

_____

Where is the pain located in your body? _____

When did the pain begin? _____

How did the pain begin? _____

(over)

What activities or actions aggravate or give rise to the pain?_____

_____

Is your pain chronic or sporadic? _____ If sporadic, how often, and when does your pain occur? _____

What activities or body positions relieve your pain?_____

_____

Is the pain or discomfort dull ☐ sharp☐ achy ☐ other☐? Explain:_____

_____

Does the pain appear to spread to other parts of your body? Explain:_____

_____

Does your pain prevent you from falling asleep or wake you from sleeping? Yes ☐ No ☐

Are there activities you cannot perform due to your pain? Explain:_____

_____

Has your pain complaint been diagnosed ? Yes ☐ No ☐. By whom?_____
Diagnosis:_____

Medical History

Are you currently under the care of a physician or other health care professional? Yes ☐ No ☐ If yes, for what condition?_____

Name of health care professional ?_____ City_____
State?_____ Phone ( )_____

Are you taking pain relief medication? Yes ☐ No ☐ If yes, please indicate the type(s) of medication you are currently taking and for how long._____

_____

Do you have allergies? Yes ☐ No ☐ If yes, please list allergens._____

_____

Please indicate (including year) if you have had broken bones, serious physical trauma, surguries, hospitalizations, childhood accidents, tailbone injuries, or head injuries. ._____

_____

_____

Current and Past Conditions

CIRCLE any of the following conditions you are experiencing **NOW.**

UNDERLINE any of the conditions you have experienced in the **PAST.**

Musculo-Skeletal
bone/joint disease
tendonitis
bursitis
arthritis
osteoporosis
muscle spasms/cramps
painful/swollen joints
headaches/ migraines
jaw pain/TMJ
neck , shoulder pain
chest pain
arm, hand pain
low back, hip pain
leg, foot pain
scoliosis
other_____

Respiratory
asthma
lung/breathing problems
respiratory allergies
other_____

Circulatory
heart condition
heart pain
high blood pressure
low blood pressure
diabetes
blood clots
phlebitis
cold hands/feet
lymphedema
circulatory disorders
varicose veins
fainting
other_____

Digestive
constipation
gas/bloating
irritable bowel syndrome
diverticulitis
eating disorders
other_____

Nervous System
nerve compression
herniated/bulging disks
epilepsy/seizures
tinnitis
fatigue
numb hands/feet
other_____

Reproductive
pregnancy
menstruation problems
PMS
other_____

Skin
skin allergies
rashes
athletes foot
warts
psoriasis
other_____

Infectious Diseases
hepatitis_____
HIV
other_____

Other
depression
kidney problems
cancer/tumors
drug/alcohol addiction
nicotine/caffeine addition
other_____

List any additional medical information which you feel is important for your therapist to know. _____

_____

_____

_____

_____

Please check off the areas that you give the therapist permission to work.

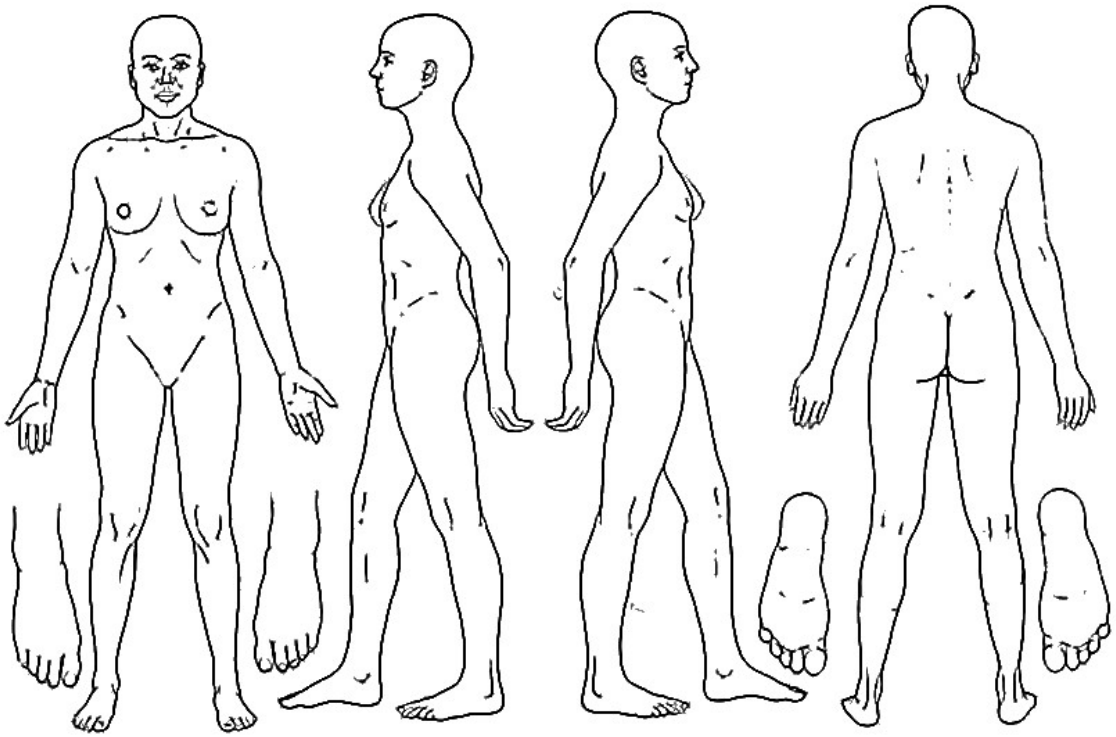
Please check the areas of your body that you give permission to receive massage:

Oback Olegs Ofeet Obuttocks Oarms and hands Oabdomen Ochest Oneck Ohead Oface

Draping will be used during the session.

Therapuetic breast massage will not be performed unless the client gives written permission.
(over)

Circle the areas on the models below which identify your area(s) of current, acute, or chronic pain or discomfort. Rate them by number: #1 = the greatest discomfort or pain



I realize that the treatment is being given for the well being of my body and mind. This includes stress reduction relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel my well being is being compromised. If at any time I feel uncomfortable for any reason and wish the massage to end, I will ask the therapist to cease the massage and the therapist will end the session.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. I have stated all medical conditions of which I am aware and will update the massage practitioner of any changes in my health status.

Clients under 17 years of age must provide written consent of a parent or guradian prior to treatment.

The massage techniques that may be applied include myofascial release, trigger point release, soft tissue manipulation, hydrothrerapy, hot/cold therapy, Swedish massage techniques, Asian massage techniques, Maya massage techniques, lymphatic massage and/or vibration-sound techniques.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____