

# CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone(h): \_\_\_\_\_ (w) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Referred by: \_\_\_\_\_ Marital Status: \_\_\_\_\_

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Is this your first professional massage? \_\_\_\_\_ If no, how frequently do you get a massage? \_\_\_\_\_

What do you hope to accomplish from today's massage? \_\_\_\_\_

Are you aware of any tension holding spots in your body? \_\_\_\_\_ If yes, location(s) \_\_\_\_\_

Describe any surgeries, hospitalizations, accidents or injuries you have had:

Less than 5 years ago: \_\_\_\_\_

More than 5 years ago: \_\_\_\_\_

What kind of care did you receive for your accidents or injuries? \_\_\_\_\_

Do you feel that you have recovered from these events? \_\_\_\_\_ Please explain: \_\_\_\_\_

Do you have any chronic, ongoing pain that you deal with on a regular basis? \_\_\_\_\_

Please explain: \_\_\_\_\_

Describe what activities cause this pain and/or make it worse: \_\_\_\_\_

Are you receiving any other type of medical treatment? \_\_\_\_\_ Please explain: \_\_\_\_\_

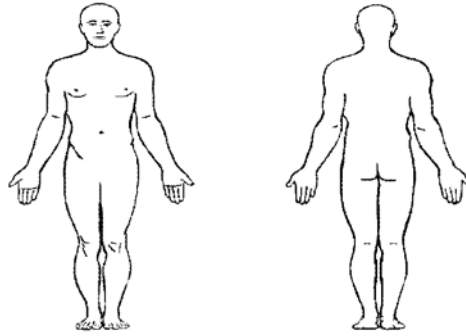
Please list any medication (vitamins, herbs or pharmaceutical) taken now or at regular intervals (include explanation of what medication is used to treat): \_\_\_\_\_  
\_\_\_\_\_

Are you currently under the care of a physician? \_\_\_\_\_ Whom? \_\_\_\_\_

Please list reason(s): \_\_\_\_\_

Are there any other health concerns you wish to discuss today? \_\_\_\_\_ If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Please indicate where you experience pain on the drawing below



Are you currently experiencing any of the following conditions?

\_\_\_\_\_ Flu or Cold      \_\_\_\_\_ Inflammation      \_\_\_\_\_ Fever      \_\_\_\_\_ Infection      \_\_\_\_\_ Contagious Disease

Please check any of the following conditions below that currently affect you or that you have experienced in the last 5 years.

**MUSCULOSKELETAL**

- \_\_\_ Fibromyalgia
- \_\_\_ Spasms/Cramps
- \_\_\_ Sprains/Strains
- \_\_\_ Osteoporosis
- \_\_\_ Postural Deviations
- \_\_\_ Gout
- \_\_\_ Osteoarthritis/Rheumatoid Arthritis
- \_\_\_ TMJ
- \_\_\_ Cysts
- \_\_\_ Bursitis
- \_\_\_ Plantar Fasciitis
- \_\_\_ Tendonitis
- \_\_\_ Torticollis
- \_\_\_ Whiplash Syndrome
- \_\_\_ Carpal Tunnel Syndrome
- \_\_\_ Sciatica
- \_\_\_ Thoracic Outlet Syndrome
- \_\_\_ Headache
- \_\_\_ Leg Pain
- \_\_\_ Arm Pain/Shoulder Pain
- \_\_\_ Low Back Pain
- \_\_\_ Mid Back Pain
- \_\_\_ Hip Pain
- \_\_\_ Other \_\_\_\_\_

**RESPIRATORY**

- \_\_\_ Pneumonia
- \_\_\_ Sinusitis
- \_\_\_ Asthma
- \_\_\_ Trouble Breathing
- \_\_\_ Dizziness
- \_\_\_ Other \_\_\_\_\_

**CIRCULATORY**

- \_\_\_ Anemia
- \_\_\_ Hemophilia
- \_\_\_ Hypertension
- \_\_\_ Low Blood Pressure
- \_\_\_ Raynaud's Disease
- \_\_\_ Varicose Veins
- \_\_\_ Heart Condition
- \_\_\_ Blood Clots/Phlebitis
- \_\_\_ Diabetes
- \_\_\_ Other \_\_\_\_\_

**DIGESTIVE**

- \_\_\_ Ulcers
- \_\_\_ Irritable Bowel Syndrome
- \_\_\_ Colitis
- \_\_\_ Gallstones
- \_\_\_ Hepatitis
- \_\_\_ Crohn's Disease
- \_\_\_ Diarrhea
- \_\_\_ Gas/Bloating
- \_\_\_ Indigestion
- \_\_\_ Other \_\_\_\_\_

**SKIN**

- \_\_\_ Fungal Infections
- \_\_\_ Acne
- \_\_\_ Impetigo
- \_\_\_ Dermatitis/Eczema
- \_\_\_ Psoriasis
- \_\_\_ Open Wound or Sore
- \_\_\_ Rashes
- \_\_\_ Warts/Moles
- \_\_\_ Athletes Foot
- \_\_\_ Other \_\_\_\_\_

**NERVOUS SYSTEM**

- \_\_\_ ALS
- \_\_\_ Multiple Sclerosis
- \_\_\_ Parkinson's Disease
- \_\_\_ Bell's Palsy
- \_\_\_ Neuritis
- \_\_\_ Spinal Cord Injury
- \_\_\_ Stroke
- \_\_\_ Trigeminal Neuralgia
- \_\_\_ Seizure Disorders
- \_\_\_ Numbness/Tingling/Twitching
- \_\_\_ Other \_\_\_\_\_

**OTHER**

- \_\_\_ Insomnia
- \_\_\_ Anxiety/Panic Attacks
- \_\_\_ PMS
- \_\_\_ Grief Process
- \_\_\_ Cancer
- \_\_\_ Substance Abuse
- \_\_\_ Pregnancy
- \_\_\_ Chronic Fatigue
- \_\_\_ HIV/AIDS
- \_\_\_ Lupus
- \_\_\_ Kidney Disease
- \_\_\_ Bladder Infection
- \_\_\_ Postoperative Situation
- \_\_\_ Edema
- \_\_\_ Other \_\_\_\_\_

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) may be charged in full for the price of the missed session.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_