

Client Name: _____ Date of Birth: _____ Gender: _____

Address: _____

Phone: _____ Email: _____

Emergency contact: _____ Phone: _____

Referred by: _____

General Massage Information

Have you received professional massage before? Yes No How recently? _____

What types of massage/bodywork do you prefer? _____

What depth of pressure do you prefer? Light Medium Firm

Primary reason for your visit: _____

When did you first notice it? _____

Describe any stressors at the time: _____

What activities (if any) provide relief? _____

What makes it worse? _____

What are your goals/desired outcomes for receiving massage/bodywork?

How do you feel today? _____

List and prioritize your current symptoms/issues:

Do these symptoms interfere with your activities of daily living (sleep, exercise, work, childcare)? Y N

Explain: _____

Medical History

List the medications you currently take:

Are you wearing contacts? Yes No

Are you pregnant? Yes No If yes, what is your projected due date? _____

Have you had any pregnancy complications? _____

Have you had any injuries or surgeries in the past?

Check any of the following health conditions that you currently have below (If you are unsure, please ask). *This information is important, as massage may not be indicated for the conditions listed below.*

- blood clots** **infections** **congestive heart failure** **contagious disease** **pitting edema**

Please check "Current" and/or "Past" to indicate any conditions below that you have experienced. Explain in the space provided, including treatment received:

- Past Current **Muscle or joint pain** (note locations) _____
- Past Current **Muscle or joint stiffness** (note locations) _____
- Past Current **Swelling/inflammation** (note location) _____
- Past Current **Back Pain** (note location) _____
- Past Current **Herniated/bulging disc/s** (note location) _____
- Past Current **Sciatica** _____
- Past Current **Arthritis** (rheumatoid, osteoarthritis) _____
- Past Current **Osteoporosis, degenerative spine/disk conditions** _____
- Past Current **Scoliosis** _____
- Past Current **Bruise easily** _____
- Past Current **Sensitive to touch/pressure** _____
- Past Current **Broken bones** _____
- Past Current **High/Low blood pressure** _____
- Past Current **Varicose veins** (note location) _____
- Past Current **Shortness of breath, asthma** _____
- Past Current **Cold hands/feet** _____
- Past Current **Skin conditions** (note type) _____
- Past Current **Numbness or tingling** _____
- Past Current **Neurological** (e.g. MS, Parkinson's, chronic pain) _____
- Past Current **Epilepsy, seizures** _____
- Past Current **Headaches/ Migraines** (note type) _____
- Past Current **Dizziness, ringing in the ears** _____
- Past Current **Fainting spells** _____
- Past Current **Diabetes** _____
- Past Current **Endocrine/ thyroid conditions** _____
- Past Current **Kidney disease/ infection** _____
- Past Current **Cancer** (note type) _____
- Past Current **Depression/ Anxiety** _____
- Past Current **Memory Loss, confusion, easily overwhelmed** _____
- Past Current **Sleep disturbance** _____
- Past Current **Digestive conditions** (e.g. Crohn's, IBS) _____
- Past Current **Gas, bloating, constipation** _____
- Past Current **Allergies** _____
- History of: **Stroke** **Heart attack** _____

Comments:

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the massage may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____