Name: _____ Date of Birth: _____ Gender:_____
Address: _____
Phone: _____ Email: _____
Occupation: _____ Referred by: _____
Emergency contact: _____ Phone:_____

## General Massage Information

Have you ever received professional massage/bodywork before? Yes □ No □ Type: _____
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? _____
Do these symptoms interfere with your activities of daily living (sleep, exercise, work, childcare)? Y □ N □
Explain:_____
How do you feel today?_____
List and prioritize your current symptoms/issues:

_____

_____

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

_____

_____

## Medical History

List the medications and/or supplements you currently take:

_____

_____

Allergies (specify allergen and reaction): _____

_____

Are you wearing contacts? Yes □ No □
Are you pregnant? Yes □ No □ If yes, what is your projected due date? _____
Past injuries, accidents, or traumas: _____

_____

Falls or injuries to the sacrum/tailbone/head: _____

_____

Surgical history (year and type) and/or recent procedures: _____

_____

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

**Musculoskeletal**

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 **Sore heels when walking** _____

**Circulatory, Cardio-pulmonary, Skin**

Past/ Current **High/Low blood pressure** _____

History of **Stroke/ heart attack** _____

Past/ Current **Varicose veins** (note location) _____

Past/ Current **Shortness of breath, asthma** _____

Past/ Current **Cold hands/feet** _____

Past/ Current **Skin conditions** (note type) _____

**Nervous System**

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** _____

**Additional comments**: _____

_____

**Gastrointestinal**

Past/ Current **Digestive conditions** (e.g. Crohn's, IBS) _____

Past/ Current **Gas, bloating, or indigestion** _____

Past/ Current **Chronic constipation** _____

Past/ Current **Loose stools/ diarrhea** _____

Past/ Current **Hemorrhoids** _____

How frequent are your bowel movements? _____ per _____

Circle all the apply: Blood in stool Mucus in stool Pain when stooling

Food allergies/ intolerances (describe) _____

_____

What is the worst item in your diet? _____

Water intake _____ glasses/ day Caffeine intake _____

**Endocrine, Other**

Past/ Current **Diabetes** _____

Past/ Current **Endocrine/thyroid conditions** _____

Past/ Current **Kidney disease/ infection** _____

Past/ Current **Cancer** (note type) _____

**Psycho-emotional**

Past/ Current **Depression** _____

Past/ Current **Anxiety** _____

Past/ Current **Memory Loss, confusion, easily overwhelmed** _____

Past/ Current **Sleep disturbance** _____

**Additional comments**: _____

_____

## Family History

Health conditions (if known) in your immediate family _____

_____

Health conditions (if known) in your maternal family line _____

_____

Health conditions (if known) in your paternal family line _____

_____

## Lifestyle, Emotional & Spiritual

What is your opinion of yourself? _____

Describe the most positive emotion you experience _____

When and where do you experience it? _____

Describe the most negative emotion you experience _____

When and where do you experience it? _____

Describe your spiritual and/or religious practice: _____

What hobbies/ activities provide you with pleasure and accomplishment? _____

_____

Describe your exercise routine (type, frequency): _____

_____

What changes would you like to achieve…

in 6 months? _____

in one year? _____

Do you use…

Tobacco products? Yes □ No □ Quantity: _____ per day

Alcohol? Yes □ No □ Quantity: _____ per day

Marijuana? Yes □ No □ Frequency: _____

Other recreational/ ceremonial drugs? _____

Have you been under treatment for substance abuse or addiction? _____

Have you experienced significant trauma? Yes □ No □

Did you undergo counseling for this? Yes □ No □ What was this like for you? _____

Is there anything you would like me to know about your trauma history? _____

_____

Additional Comments:

## Female Reproductive Health History

Please circle "Current" and/or "Past" to indicate any conditions below that you have experienced. Explain or add relevant notes in the spaces provided.

Past/ Current **Painful Periods** _____

Past/ Current **Heaviness in pelvis prior to menses**

Past/ Current **Excessive bleeding** _____ pads per hour

Past/ Current **Bloating/ Water retention** _____

Past/ Current **Endometriosis** (note location/s, if known) _____

Past/ Current **Uterine or Cervical polyps** _____

Past/ Current **Vaginal/ uterine infections** _____

Past/ Current **Bladder infections** _____

Past/ Current **Painful intercourse** _____

Past/ Current **Episodes of Amenorrhea** (missed periods) How long? _____

Past/ Current **Irregular cycles** (early or late?) _____

Past/ Current **Dark, thick blood** (circle): beginning end both _____

Past/ Current **Headache or migraine with menses** _____

Past/ Current **Ovulation** (circle all that apply) **painful / failure to ovulate** _____

Past/ Current **Fibroids** (location/s, if known) _____

Past/ Current **Cysts** (location/s, if known) _____

Past/ Current **Urinary Incontinence** _____

Past/ Current **Vaginal Dryness** _____

Past/ Current **Prolapse** (circle all that apply) **Uterine** **Bladder** (cystocele) **Rectum** (rectocele)

Rate your interest in sex: High □ Moderate □ Low □ None □

Do you ever have difficulty experiencing orgasms? Yes □ No □

Method of contraception (circle if applicable):

none condoms pill patch IUD diaphragm rhythm method fertility awareness other _____

Length of time using this method: _____

Are you experiencing or have you experienced any fertility challenges? Yes □ No □

Describe any fertility treatment you have received (IUI, IVF, etc.) _____

### Menstrual History

Age at first period: _____ What was this like for you? _____

Are you trying to conceive? Yes □ No □ Are you pregnant? Yes □ No □ Unsure □

Date most recent period began _____

### Pregnancy History

Check below if you have experienced:

□ Premature births □ Spotting during pregnancy □ Weak newborns □ "Incompetent" Cervix

Number of Pregnancies: _____
Number of Miscarriages: _____ Date(s): _____
Number of Terminations: _____ Date(s): _____
Number of births: _____ Date(s): _____
Complications with any of the above, describe: _____
_____
_____

Describe your experience with:

Pregnancy: _____
_____
Labor: _____
_____
Birthing: _____
_____
Postpartum: _____
_____

**Maternal family reproductive health history**

Circle all that apply: Infertility Fibroids Endometriosis PMS
Cancer (type) _____ Menstrual problems: _____
Other: _____
Medications your mother took when she was pregnant with you (if known): _____
Your birth trauma (if known): _____

**Menopause**

Age symptoms began: _____ Are they getting (circle one): Worse Better Same
Are you on/have you been on hormone replacement therapy? Yes □ No □ How long? _____
Name and dose: _____
Reason for stopping (if you stopped): _____
Age of mother at menopause (if known): _____ Concerns/ Experience: _____

Check all symptoms that apply to you:

| | | | |
|---|---|---|---|
| □ Hot Flashes | □ Insomnia | □ Disturbed sleep pattern | □ Fatigue |
| □ Memory Loss | □ Mood Swings | □ Vaginal Discharge | □ Vaginal Dryness |
| □ Depression | □ Anxiety | □ Irritability | □ Spotting |
| □ Flooding | □ Irregular Menses | □ Painful Intercourse | |

□ Libido increased/ decreased (circle all that apply)
Is there anything else you would like me to know? (add below)

## Male Reproductive Health History

Please circle “Current” and/or “Past” to indicate any conditions below that you have experienced. Explain or add relevant notes in the spaces provided.

Past/ Current **Urinary incontinence/ dribbling** _____

Past/ Current **Weak or interrupted urine flow** _____

Past/ Current **Difficult starting or continuing urine stream** _____

Past/ Current **Pain/ burning with urination** _____

Past/ Current **Nocturnal urination** How many times/night? _____

Past/ Current **Urinary retention** _____

Past/ Current **Blood or pus in urine** _____

Past/ Current **Frequent bladder or kidney infections** When? _____

Past/ Current **Pain in low back, esp after intercourse** _____

Past/ Current **Pelvic pressure** _____

Past/ Current **Insatiable sex drive** _____

Past/ Current **Pain or discomfort in** (circle all the apply): penis testicles rectum

Past/ Current **Pain or discomfort in inner thighs** (circle all the apply): left right both

Past/ Current **Pain or discomfort between scrotum and testicles** _____

Past/ Current **Erection** (circle all that apply)**:** difficulty obtaining / difficulty maintaining / painful ejaculation

Results of PSA (prostate specific antigen) test if known: _____ Date: _____

Results of sperm count (if applicable and known): _____ Date: _____

Family history of prostate disease: □ Yes □ No Type: _____ Relationship: _____

Family history of cancer: □ Yes □ No Type: _____

Sexually transmitted infection(s): □ Yes □ No Type: _____ Relationship: _____

Do you have a history of trauma? □ Yes □ No

What would you like me to know about your trauma history? _____

_____

Did you undergo you counseling for this? □ Yes □ No Type: _____

What was that like for you? _____

_____

Additional 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/ Guardian Signature (in case of a minor): Date:

_____ _____