

Client Information

Name _____

Date of Birth _____

Address _____

Referred by _____

City _____ State _____ ZIP _____

Date of initial visit _____

Phone Numbers: Home (_____) _____

Work (_____) _____

Emergency Contact Person

Email Address _____

Name _____

Primary Physician _____

Phone _____

How did you hear about us?

Family / Friend Website Internet - Search Engine: _____ Other: _____

Massage Experience

Is this your first visit to a professional massage therapist? _____

If you have been to a professional massage therapist before:

How often do you get a massage? _____ What pressure do you prefer? _____

What are your expectations of this visit? _____

Health History

Check the body movements that you perform regularly: Sitting Stopping Lifting Other: _____
 Standing Bending Driving

Which movements cause pain? _____

What is your occupation? _____

What sports or regular exercises do you regularly participate in? _____

Have you ever had surgery? _____ Explain: _____

Have you ever been hospitalized? _____ Explain: _____

Are you receiving any other type of medical treatment? _____ Explain: _____

Are you currently taking any medications? _____

If yes, please list medications and what they are for: _____

Please check any conditions that you currently experience, or that you have experienced in the last five 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 _____

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 _____

Nervous System

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

Respiratory

- Pneumonia
- Sinusitis
- Asthma
- Trouble Breathing
- Dizziness
- Other _____

Skin

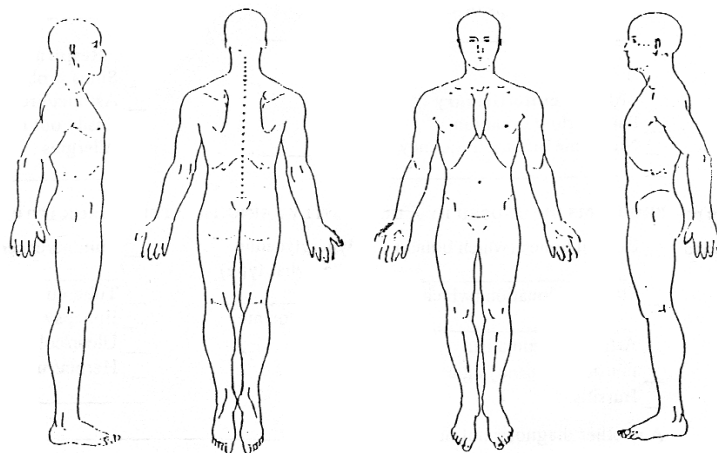
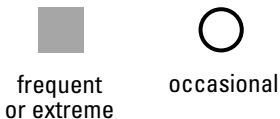
- Fungal Infections
- Acne
- Impetigo
- Dermatitis/Eczema
- Psoriasis
- Open Wound or Sore
- Rashes
- Warts/Moles
- Athletes Foot
- Other _____

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 _____

Where do you feel pain, soreness or discomfort?

Please *shade* in anywhere you feel frequent muscle or joint pain and stiffness, and *circle* the areas where you feel pain occasionally:



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.

Signature: _____ Date: _____