Client Information & Health History

Name____

Address____

City____________________________ State__________ Zip Code___________

Phone Number_________________________ Birth Date_____________________

Email Address____

Referred by____

Is this your first professional massage? Yes No

If no, how frequently do you receive massage?_______________________________

What other therapies have you tried?

____

Are you under a doctor or other health practitioner's care? Yes No

If yes, please give a brief description:

____

____

Please check any of the following conditions that apply to you:

- ◻ Alcohol use
- ◻ Arthritis
- ◻ Asthma
- ◻ Bruise easily / Current Bruises
- ◻ Cancer / Tumors
- ◻ Diabetes
- ◻ Drug use
- ◻ Edema
- ◻ Epilepsy
- ◻ Fever
- ◻ Fibromyalgia
- ◻ Fractures
- ◻ Headaches
- ◻ Heart attack / Pace maker
- ◻ Heart disease
- ◻ High blood pressure
- ◻ Illness / Disease
- ◻ Insomnia
- ◻ Localized Infections
- ◻ Low blood pressure
- ◻ Medications
- ◻ Open Wounds
- ◻ Pacemaker
- ◻ Painful joints / Bursitis
- ◻ Painful menstruation
- ◻ Phlebitis / Thrombosis
- ◻ Poor circulation
- ◻ Pregnancy ______months
- ◻ Sinus infection
- ◻ Skin Irritation / Rash
- ◻ Skin conditions / Skin Diseases
- ◻ Smoking
- ◻ Stroke
- ◻ Swelling
- ◻ TMJ
- ◻ Varicose veins
- ◻ **Nut Allergies**
- ◻ **Other Allergies**

Please describe any surgeries, hospitalizations, accidents or injuries you have had, and any open or healing wounds:

____

____

____

Please list any medications you are currently taking: (specifically pain killers, anti-inflammatory, blood thinners, and muscle relaxers)

____

____

Describe the nature of the pain – is it local, does it radiate outward, is there a position of comfort, or restriction of movement?

____

____

When did to "problem" start?

____

What has helped relieve the "problem"?

____

What are your expectations for your session today?

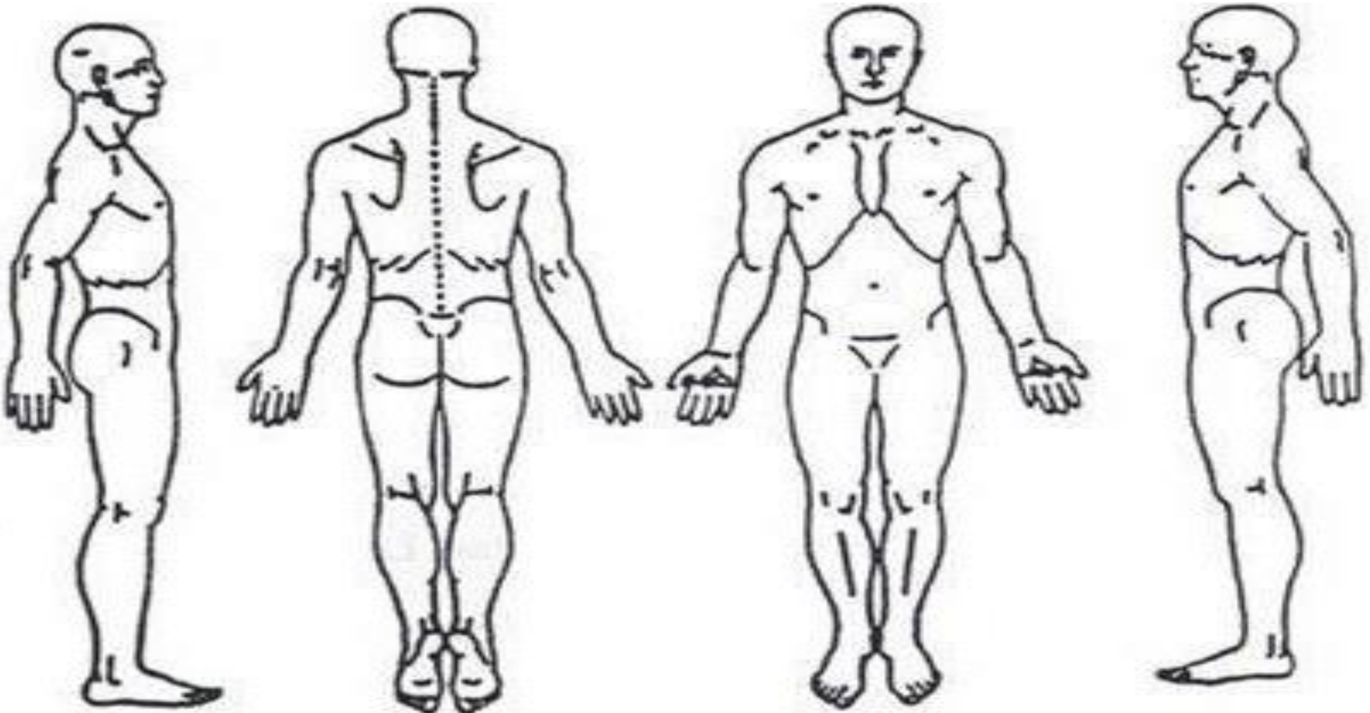
____

Other health conditions or comments:

____

Are you wearing any face or eye makeup? Yes No

Please circle areas on the diagram below that you feel need extra work. Cross out any areas you would like to be avoided.



Preferred Pressure (circle one): **Light** **Medium** **Deep** **???**

By signing this document, I, ________________________________, understand that this is a confidential medical history and that all medical records and conversations with my therapist will remain private. Advice from the therapist is non-medical and does not replace seeing a doctor. I also understand that my therapist will only work within her scope of practice, that I have the right to ask my therapist not to massage any part of my body I am not comfortable having massaged, and that this massage is for the purposes of relaxation and the relief of stress and muscular tension. I give my consent for my therapist to treat me.

Signature____ Date_______________________