HEALTH INFORMATION

A. Client information

Name: ______________________ Birth date: ______________________

Address: ______________________ Phone: ______________________

Alt phone: ______________________

Occupation: ______________________

Email: ______________________ Join our e-mailing list: Yes ☐ No ☐

Emergency contact: ______________________ Phone: ______________________

Relationship to client: ______________________

B. Lifestyle information

List daily activities (work, home, recreational):

Mark the activities affected by your condition / All of the above | Mark other activities affected: sleep | washing | dressing | fitness

List medications/pain relievers/supplements taken in the last 3 months:

How do you reduce stress? Pain?

Have you received massage before? Yes No | Date of last session:

Reason for last session: | What was the outcome?

What are your goals for receiving massage?

Mark the areas you are comfortable receiving massage: ☐ face ☐ scalp ☐ neck ☐ back

☐ upper chest ☐ abdomen ☐ arms ☐ hands ☐ legs ☐ feet ☐ glutes ☐ thighs

Additional comments:

C. Health concerns

Primary: ______________________ ☐ mild ☐ moderate ☐ disabling

My symptoms are… ☐ intermittent ☐ constant ☐ ↑ w/activity ☐ ↓ w/activity

☐ getting worse ☐ getting better Comments: ______________________

Treatment received: ______________________

Secondary: ______________________ ☐ mild ☐ moderate ☐ disabling

My symptoms are… ☐ intermittent ☐ constant ☐ ↑ w/activity ☐ ↓ w/activity

☐ getting worse ☐ getting better Comments: ______________________

Treatment received: ______________________

D. Health history

List and explain any conditions for the past 5 years. Please include dates, treatment, and current status.

Surgeries: ______________________________

Accidents: ______________________________

Major illnesses: ______________________________

Check all conditions, please *circle* if current — *Comments*

General

				Comments
☐	Headaches	☐	Infectious	
☐	Pain	☐	Fever	
☐	Sleep disturbances	☐	Sinus	
☐	Fatigue	☐	Other	

Skin conditions

						Comments
☐	Rashes	☐	Athlete's foot, warts	☐	Other	

Muscles and Joints

				Comments
☐	Rheumatoid arthritis	☐	Spasms, cramps	
☐	Osteoarthritis	☐	Sprains, strains	
☐	Scoliosis	☐	Tendonitis, bursitis	
☐	Broken bones	☐	Stiff/painful joints	
☐	Spinal problems	☐	Weak or sore muscles	
☐	Disk problems	☐	Neck, shoulder, arm pain	
☐	Lupus	☐	Low back, hip, leg pain	
☐	TMJ, jaw pain	☐	Other	

Nervous System

				Comments
☐	Head injuries, concussions	☐	Sciatica, shooting pain	
☐	Dizziness, ringing in ears	☐	Chronic pain	
☐	Loss of memory, confusion	☐	Depression	
☐	Numbness, tingling	☐	Other	

Respiratory, Cardiovascular

				Comments
☐	Heart disease	☐	Poor circulation	
☐	Blood clots	☐	Swollen ankles	
☐	Stroke	☐	Varicose veins	
☐	Chest pain, shortness of breath	☐	Lymphadema	
☐	High / low blood pressure	☐	Asthma	
☐	Irregular heart beat	☐	Other	

Digestive / Elimination System

				Comments
☐	Bowel dysfunction	☐	Abdominal pain	
☐	Gas, bloating	☐	Bladder/kidney dysfunction	

Endocrine System

				Comments
☐	Thyroid dysfunction	☐	Diabetes	

Reproductive System

☐	Pregnancy	☐	Painful, emotional menses	☐	Fibrotic cysts

Cancer/Tumors

				Comments
☐	Benign	☐	Malignant	

Habits

				Comments
☐	Tobacco	☐	Alcohol	
☐	Drugs	☐	Coffee, soda	

E. Contract and consent for care

I promise to participate fully in my health care. I will make sound choices regarding my treatment plan based on the information provided by my massage therapist and my experience of those suggestions. I agree to participate in the self-care program we select. I promise to inform my practitioner any time I feel my wellbeing is threatened or compromised. I expect my massage therapist to provide safe and effective treatment. I have provided all my known medical information and will inform my practitioner of any changes in my health. I acknowledge that massage therapy is not a substitute for medical diagnosis and treatment. I give my consent to receive massage.

Signature: ____________________________ Date: ________________