

## Health Information

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### Client Contact Information

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Referred by: \_\_\_\_\_  
Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Physician/Health-care Provider name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes  No

### Massage Information

Have you ever received professional massage/bodywork before? Yes  No   
How recently? \_\_\_\_\_  
What types of massage/bodywork do you prefer? \_\_\_\_\_  
What kind of pressure do you prefer? Light Medium Firm  
What are your goals/expected outcomes for receiving massage/bodywork?  
\_\_\_\_\_  
\_\_\_\_\_

How do you feel today? \_\_\_\_\_

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):  
\_\_\_\_\_  
\_\_\_\_\_

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No  
Explain:  
\_\_\_\_\_  
\_\_\_\_\_

List the medications you currently take:  
\_\_\_\_\_  
\_\_\_\_\_

Are you wearing contacts? Yes  No   
Are you wearing dentures? Yes  No   
Are you wearing a hairpiece? Yes  No   
Are you pregnant? Yes  No



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Have you had any injuries or surgeries in the past that may influence today's treatment?

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Circle any of the following health conditions that you currently have (If you are unsure, please ask):

blood clots, infections, congestive heart failure, contagious diseases, pitted edema

Please answer honestly, as massage may not be indicated for the above conditions.

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

- Current Past Muscle or joint pain \_\_\_\_\_
- Current Past Muscle or joint stiffness \_\_\_\_\_
- Current Past Numbness or tingling \_\_\_\_\_
- Current Past Swelling \_\_\_\_\_
- Current Past Bruise easily \_\_\_\_\_
- Current Past Sensitive to touch/pressure \_\_\_\_\_
- Current Past High/Low blood pressure \_\_\_\_\_
- Current Past Stroke, heart attack \_\_\_\_\_
- Current Past Varicose veins \_\_\_\_\_
- Current Past Shortness of breath, asthma \_\_\_\_\_
- Current Past Cancer \_\_\_\_\_
- Current Past Neurological (e.g. MS, Parkinson's, chronic pain) \_\_\_\_\_
- Current Past Epilepsy, seizures \_\_\_\_\_
- Current Past Headaches, Migraines \_\_\_\_\_
- Current Past Dizziness, ringing in the ears \_\_\_\_\_
- Current Past Digestive conditions (e.g. Crohn's, IBS) \_\_\_\_\_
- Current Past Gas, bloating, constipation \_\_\_\_\_
- Current Past Kidney disease, infection \_\_\_\_\_
- Current Past Arthritis (rheumatoid, osteoarthritis) \_\_\_\_\_
- Current Past Osteoporosis, degenerative spine/disk \_\_\_\_\_
- Current Past Scoliosis \_\_\_\_\_
- Current Past Broken bones \_\_\_\_\_
- Current Past Allergies \_\_\_\_\_
- Current Past Diabetes \_\_\_\_\_
- Current Past Endocrine/thyroid conditions \_\_\_\_\_
- Current Past Depression, anxiety \_\_\_\_\_
- Current Past Memory Loss, confusion, easily overwhelmed \_\_\_\_\_

Comments:

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## Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes 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. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent or Guardian Signature (in case of a minor): \_\_\_\_\_

Date: \_\_\_\_\_

