



CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile: _____ Work: _____

E-Mail: _____ Referred by: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Do you exercise?: _____ What do you do?: _____ How often?: _____

Current medications: _____

Are you currently experiencing any of the following conditions? Please check (✓)

Flu or Cold ___ Inflammation ___ Fever ___ Infection ___ Contagious Disease ___

Any of the following conditions below that currently affect you or that you have experienced in the last 5 years.

CIRCULATORY SYSTEM

- Anemia
- Hemophilia
- Hypertension
- Low Blood Pressure
- Raynaud's Disease
- Varicose Veins
- Heart Condition
- Blood Clots/Phlebitis
- Diabetes
- Swelling
- Other _____

DIGESTIVE SYSTEM

- Ulcers
- Irritable Bowel Syndrome
- Colitis
- Gallstones
- Hepatitis
- Crohn's Disease
- Diarrhea
- Gas/Bloating
- Indigestion
- Bleeding
- Constipation
- Difficulty swallowing
- Other _____

SKIN

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

RESPIRATORY SYSTEM

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

MUSCULOSKELETAL SYSTEM

- Fibromyalgia
- Spasms/Cramps
- Sprains/Strains
- Osteoporosis
- Gout
- Osteoarthritis/Rheumatoid Arthritis
- TMJ
- Cysts
- Bursitis
- Plantar Fasciitis
- Tendonitis
- Whiplash Syndrome
- Carpal Tunnel Syndrome
- Sciatica
- Thoracic Outlet Syndrome
- Leg Pain
- Arm Pain/Shoulder Pain
- Low Back Pain
- Mid Back Pain
- Hip Pain
- Other _____

NERVOUS SYSTEM

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

OTHER

- Insomnia
- Sleep Apnea
- Anxiety/Panic Attacks
- Physical/Emotional Abuse
- Substance Abuse
- Grief Process
- Cancer
- Chronic Fatigue Syndrome
- HIV/AIDS
- Lupus
- Kidney Disease
- Bladder Infection
- Depression
- Migraines
- Frequent Headaches
- Ear/nose/throat infection
- Glaucoma
- Visions problems
- Other _____

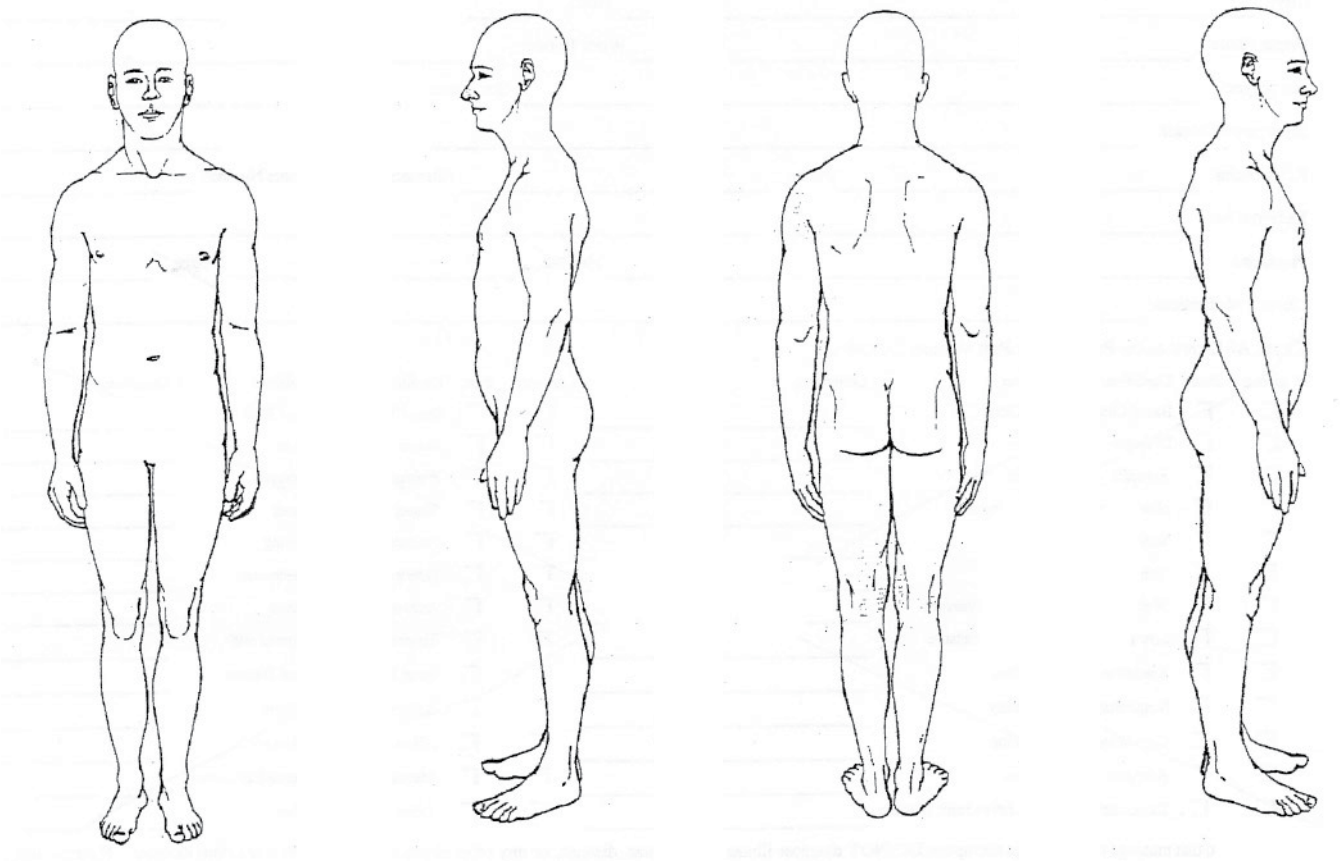
Mark below as indicated:

"P" for areas of pain.

"X" for joint/muscle stiffness.

"N" for areas of numbness/tingling.

"S" for swelling



I understand that massage therapists DO NOT diagnose illness, disease, or any other physical or mental disorder. Nothing that is said or done should be misconstrued as such. Massage therapy is not a substitute for medical examination and/or diagnosis.

Because massage/bodywork is contraindicated (should not be done) under certain medical conditions, I affirm that I have stated all my known medical conditions and shall take it upon myself to keep my massage therapist updated on my physical health. I also agree that there shall be no liability on the practitioner's part should I neglect to do so.

CONSENT FOR CARE: It is my choice to receive massage therapy. I give my consent to receive treatment. I understand that I may withdraw this consent at any time during the treatment, for any part of the treatment, for any reason. 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 in full.

I agree that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) may be charged in full for the price of the missed session.

Would you like an appointment reminder?: Yes No Phone call E-Mail Text message

Signature: _____ Date: _____

Signature of parent or guardian: _____ Date: _____

(For clients under 18 yrs, parent/guardian signature is required for treatment.)