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 □ Do you have a physician referral/prescription? Yes □ No □ Are you seeking insurance reimbursement? 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:
____

Health History

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

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:

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

Client Signature: ____ Date:________

Parent or Guardian Signature (in case of a minor): _____________________ Date:________