PERSONAL CONTACT INFORMATION

Name: _____ Age: _____ Date of Birth: _____
Street Address: _____ Home phone: (_____) _____
City: _____ Cell phone: (_____) _____
State / Zip: _____ E-Mail Address: _____
Employer: _____ Work Phone: (_____) _____
Referred By: _____ Emergency Contact: _____
Personal Physician: _____ Emergency Contact #: (_____) _____

MASSAGE HISTORY / PREFERENCES

Have you received professional massage before? ☐ Yes ☐ No If yes, date of last massage: _____
What results do you want from your session(s)? _____
What areas would you like prioritized? _____

MEDICAL HISTORY

Major Illnesses, accidents and/or injuries: _____

_____

Please check any of the following that may apply: ☐ Wear contact lenses ☐ Communicable Illness
☐ Pregnant or trying to become pregnant ☐ Infection or inflammation ☐ Allergies to oils or lotions

Check any of the following conditions that you are experiencing, or have experienced in the past:

	Current	Past		Current	Past
Heart problems	☐	☐	Arthritis/ Lumbago/ Gout	☐	☐
High Blood Pressure	☐	☐	Low Back Pain	☐	☐
Low Blood Pressure	☐	☐	Sciatica/ Numbness	☐	☐
Varicose Veins	☐	☐	Poor Circulation	☐	☐
Neck/ Spinal Injury	☐	☐	Migraines/ Headaches	☐	☐
Osteoporosis	☐	☐	Ovarian/ Menstrual Problems	☐	☐
Diabetes	☐	☐	Kidney/ Bladder Problems	☐	☐
Cancer	☐	☐	Bursitis/ Tendonitis	☐	☐
Respiratory Problems	☐	☐	Insomnia	☐	☐
Hayfever/ Allergies	☐	☐	Digestive Problems	☐	☐
Chronic Illness/ Pain	☐	☐	Skin Disorders	☐	☐
Fibromyalgia/ C.F.S.	☐	☐	Herpes/ Shingles	☐	☐
T.M.J./ Jaw Pain	☐	☐	Drug/ Alcohol Addiction	☐	☐
Lupus	☐	☐	Caffeine/ Nicotine Addiction	☐	☐

Please note any other medical condition that is affecting you: _____
Are you currently under the care of a physician for any of the above conditions? ☐ Yes ☐ No
Please list any medications you are taking: _____

PLEASE READ AND SIGN

I certify that the information provided above is true and accurate and that it is my choice to receive massage therapy. I agree to immediately notify my practitioner if any of the above listed conditions appear or change or if at any time the massage treatment causes any adverse physical reactions. I understand that massage practitioners do not diagnose Illness or disease or any physical or mental disorders. I also acknowledge that massage is not a substitute for medical treatment, examination or diagnosis and that it is recommended that I see my primary health care provider for those services. I recognize that I am responsible for keeping my scheduled appointments and I agree to pay for the treatments at the time of service unless otherwise arranged in advance. I also understand that if I fail to keep my scheduled appointment I may be responsible for the cost of the therapist's time.

_____ _____
Signature Date

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

- ☐ Headaches
- ☐ Joint stiffness/swelling
- ☐ Spasms/cramps
- ☐ Broken/fractured bones
- ☐ Strains/sprains
- ☐ Back, hip pain
- ☐ Shoulder, neck, arm, hand pain
- ☐ Leg, foot pain
- ☐ Chest, ribs, abdominal pain
- ☐ Problems walking
- ☐ Jaw pain/TMJ
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Other: _____

Circulatory and Respiratory

- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Cold feet or hands
- ☐ Cold sweats
- ☐ Stroke
- ☐ Heart condition
- ☐ Allergies
- ☐ Asthma
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Other: _____

Skin

- ☐ Rashes
- ☐ Allergies
- ☐ Athlete's foot
- ☐ Acne

Digestive

- ☐ Indigestion
- ☐ Constipation
- ☐ Intestinal gas/bloating
- ☐ Diarrhea
- ☐ Irritable bowel syndrome
- ☐ Crohn's disease
- ☐ Colitis
- ☐ Other:_____

Nervous System

- ☐ Numbness/tingling
- ☐ Fatigue
- ☐ Sleep disorders
- ☐ Ulcers
- ☐ Paralysis
- ☐ Herpes/shingles
- ☐ Cerebral Palsy
- ☐ Epilepsy
- ☐ Chronic Fatigue Syndrome
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's disease
- ☐ Other: _____

Reproductive System

- ☐ Pregnancy

Other

- ☐ Loss of Appetite
- ☐ Depression
- ☐ Difficulty concentrating
- ☐ Hearing impaired
- ☐ Visually impaired
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Post/Polio Syndrome
- ☐ Cancer
- ☐ Other: _____

I understand that a massage therapist does not diagnose disease, illness, or prescribe any treatment or drugs, nor do they provide spinal manipulation. I understand that draping will be used at all times and that breast massage will not be administered on female clients. I understand that if I become uncomfortable for any reason that I may ask the therapist to end the massage session and they will end the session. I understand that the massage therapist may end the session for any inappropriate behavior. I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client's Signature _____ Date:_____