

Name: _____ Phone: _____

Address: _____

City/State/Zip: _____

Email: _____ DOB: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

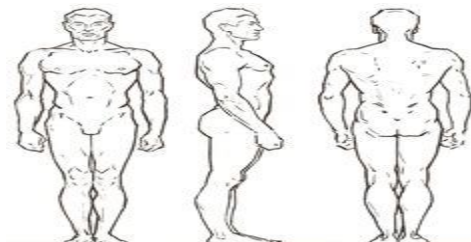
The following information will be used to help plan safe and effective massage session.

Please answer the questions to the best of you knowledge.

Date of Initial visit _____

1. Have you had professional massage before? Yes No
If yes, how often do you receive massage therapy? _____
2. Do you have any difficulty lying on your front, back, or side? Yes No
If yes, please explain _____
3. Do you have any allergies to oils, lotions, or ointments? Yes No
If yes, please explain _____
4. Do you have sensitive skin? Yes No
5. Are you wearing contact lenses () dentures () a hearing aid () ?
6. Do you sit for long hours at a workstation, computer, or driving? Yes No
If yes, please describe _____
7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
If yes, please describe _____
8. Do you experience stress in your work, family, or other aspect of your life? Yes No
If yes, how do you think it has affected your health?
Muscle tension () anxiety () insomnia () irritability () other _____
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes NO
If yes, please identify _____
10. Do you have any particular goals in mind for this massage session? Yes No
If yes, please explain _____

Circle any specific areas you would like the massage therapist to concentrate on during the session:



Medical History

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

11. Are you currently under medical supervision? Yes No

 If yes, please explain _____

12. Do you see a chiropractor? Yes No

13. Are you currently taking any medication? Yes No

 If yes, please list _____

14. Please check any condition listed below that applies to you:

- | | |
|---|--|
| <input type="checkbox"/> contagious skin condition | <input type="checkbox"/> phlebitis |
| <input type="checkbox"/> open sores or wounds | <input type="checkbox"/> deep vein thrombosis/blood clots |
| <input type="checkbox"/> easy bruising | <input type="checkbox"/> joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis |
| <input type="checkbox"/> recent accident or injury | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> recent fracture | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> recent surgery | <input type="checkbox"/> headaches/migraines |
| <input type="checkbox"/> artificial joint | <input type="checkbox"/> cancer |
| <input type="checkbox"/> sprains/strains | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> current fever | <input type="checkbox"/> decreased sensation |
| <input type="checkbox"/> swollen glands | <input type="checkbox"/> back/neck problems |
| <input type="checkbox"/> allergies/sensitivity | <input type="checkbox"/> fibromyalgia |
| <input type="checkbox"/> heart condition | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> high or low blood pressure | <input type="checkbox"/> carpal tunnel syndrome |
| <input type="checkbox"/> circulatory disorder | <input type="checkbox"/> tennis elbow |
| <input type="checkbox"/> varicose veins | <input type="checkbox"/> pregnancy If yes, how may months? _____ |
| <input type="checkbox"/> atherosclerosis | |

Please explain any condition that you have marked above _____

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____

Draping will be used during the session – only the area being worked on will be uncovered.

Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for nay client under the age of 17.

Signature of client _____ Date _____

Signature of Massage Therapist _____ Date _____