Confidential Client Information and Health History

Name: ______________________________ Date of Birth: ______________

Phone (Day): ______________ Phone (Eve): ______________ Email: ______________________

Address: ______________________________ City/State/Zip: ______________________

Occupation: ______________________________ Referred by: ______________________

Emergency Contact: ____________________ Phone: ____________ Relationship: ______________

Primary Care Physician: ______________________________ Phone: ______________

Have you received professional massage before? ________ If yes, how frequently? ______________________

Do you have any particular goals for today's session? ______________________________

Is there any area of the body where you are experiencing tension, stiffness, pain, or other discomfort? ________

If yes, please identify: ____

Have you been hospitalized and/or had surgery within the past 5 years? ________

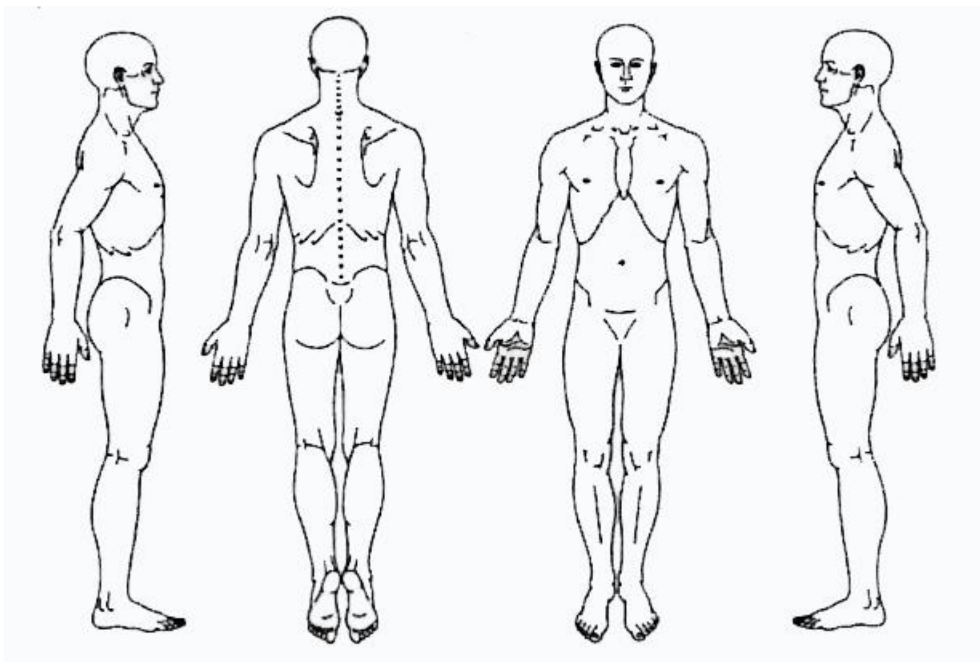
If yes, please explain: ____

Have you had recent injuries, serious illness, or suffer from a chronic condition/s? ________

If yes, please explain: ____

Are you currently pregnant? ________ If so, how far along? ______________________________

Please indicate any areas of pain below:



Please check any conditions below that you have experienced in the past 5 years:

( ) Anxiety/Panic Attacks
( ) Depression
( ) Insomnia
( ) Fibromyalgia
( ) Chronic Fatigue
( ) Postural Deviations
( ) Spine/Disc Issues
( ) Osteoporosis
( ) Joint Replacement
( ) Osteoarthritis
( ) Rheumatoid Arthritis
( ) Gout
( ) TMJ Disorder
( ) Plantar Fasciitis
( ) Tendonitis/Bursitis
( ) Headaches
( ) Dizziness
( ) Diabetes
( ) Heart Condition
( ) Low/High Blood Pressure
( ) Stroke
( ) Cancer
( ) Swelling/Edema
( ) Numbness/Tingling/Twitching
( ) Neuropathy/Decreased Sensation
( ) Varicose Veins
( ) Hepatitis
( ) HIV/AIDS
( ) Seizure Disorder
( ) Auto-Immune Disorder

( ) Skin Condition(s): ______________________________

( ) Allergies: ______________________________

( ) Other/Any additional info on above condition(s) that you would like to provide: ______________________________

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Are you currently taking any medications? __________ If so, please list: ______________________________

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The following sometimes occur during massage. They are normal responses to relaxation:
moving or changing position • sighing, yawning, change in breathing • stomach gurgling • falling asleep
emotional feelings and/or expression • movement of intestinal gas • energy shifts • memories

By signing below, I acknowledge:

- Informed written consent must be provided by parent or legal guardian for any client under the age of 18.
- Draping will be used during the session – only the area being addressed will be uncovered.
- The massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort.
- Massage should not be construed as a substitute for medical examination, diagnosis, or treatment; and I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware.
- Massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness; and nothing said in the course of the session given should be construed as such.
- Because massage 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.
- This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
- I am responsible for full payment for any appointments cancelled or missed without 24 hours' advance notice.

Signature: ______________________________ Date: ____________________