

Massage Therapy Client Information

Last Name _____ First Name _____ Occupation _____
Address _____
Phone _____ Email _____ Ht _____ Wt _____ circle: M F
Birthdate _____ How did you learn about our services? _____

Medical History

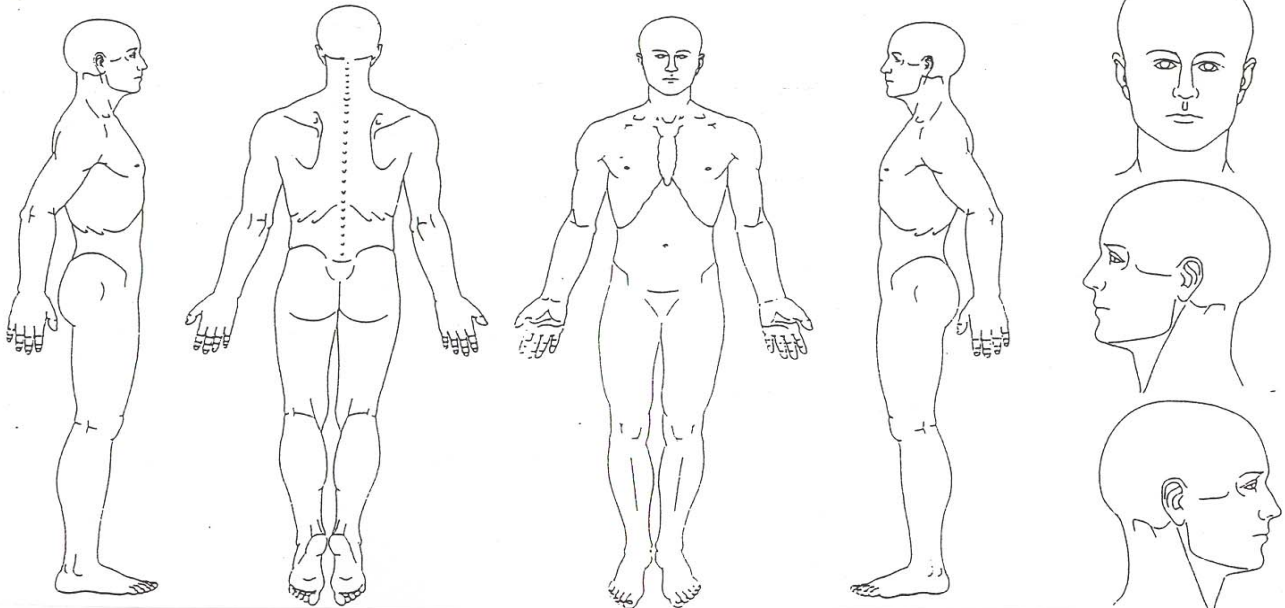
Are you currently under a physician's care for anything I need to be aware of? _____
Surgeries/dates _____
Diagnosed with illness, disease in the last two years (describe) _____ pregnant? _____
Been in a car accident or suffered trauma to your body/dates _____
Bruise easily _____ "brittle bones" _____ broken bones/dates _____
Physical therapy/dates _____ high/low blood pressure _____ diabetes _____
Skin allergies, skin condition, skin lesions or wounds (describe) _____
Have you ever received radiation therapy? _____ chemotherapy? _____ other? _____
Name all prescribed and over-the-counter medications including herbs & supplements you take and for what reason _____

(Massage can increase your body's absorption of these products.)

Pain History

Are you currently experiencing pain in your joints or muscles? _____ Describe your pain and its location _____
How long have you experienced this pain? _____ What makes it worse? _____
What makes it better? _____ Have you used heat or cold packs? _____
Does this pain affect your ability to work, play, exercise? _____ In what way? _____
What do you think may have caused this pain? _____

Using the anatomical figures below, put a "X" in areas of regional pain:



Do you regularly allow relaxing time-out for yourself? _____ Do you believe this massage session will be helpful to you? _____
Have you received a massage before? _____ If yes, what type of pressure have you found to be most beneficial? _____
Signature _____ Date _____

Note: You may pay for this visit by check or cash at the front desk. If you wish to leave a cash gratuity (optional), please give it directly to your therapist.

