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## CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (H): \_\_\_\_\_ Mobile: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email Address: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Male      Female      Referred by: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you wear contacts: \_\_\_\_\_ Do you exercise? \_\_\_\_\_ If yes, how? \_\_\_\_\_

How much water do you drink per day? \_\_\_\_\_ Do you consider yourself stressed? \_\_\_\_\_

Is this your first professional massage? \_\_\_\_\_ If no, how frequently do you get a massage? \_\_\_\_\_

What do you hope to accomplish from today's massage? \_\_\_\_\_

Are you aware of any tension holding spots in your body? \_\_\_\_\_ Where? \_\_\_\_\_

Please describe any surgeries, hospitalization, accidents or injuries you have had:

Less than 5 years ago: \_\_\_\_\_

More than 5 years ago: \_\_\_\_\_

What kind of care did you receive for your accidents/injuries? \_\_\_\_\_

Do you feel that you have recovered from these events? \_\_\_\_\_ Please explain: \_\_\_\_\_

Do you have any chronic, ongoing pain that you deal with on a regular basis? \_\_\_\_\_

Please explain: \_\_\_\_\_

Describe what activities cause this pain and/or make it worse: \_\_\_\_\_

Are you currently receiving any other type of medical or therapeutic treatment? \_\_\_\_\_

Please explain: \_\_\_\_\_

Please list any medication (vitamins, herbs or pharmaceuticals) taken now or at regular intervals.

Include an explanation of what the medication is used to treat: \_\_\_\_\_

Are you currently under the care of a physician? \_\_\_\_\_ Whom? \_\_\_\_\_

Please list reasons: \_\_\_\_\_

Are there any health concerns you wish to discuss today? \_\_\_\_\_ If so, please describe: \_\_\_\_\_

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Are you currently experiencing any of the following conditions?

Flu or Cold \_\_\_ Inflammation \_\_\_ Fever \_\_\_ Infection \_\_\_ Contagious Disease \_\_\_

Please check any of the following conditions below that currently affect you or that you have experienced in the last 5 years.

**CIRCULATORY SYSTEM**

Anemia  
Hemophilia  
Hypertension  
Low Blood Pressure  
Reynaud's Disease  
Varicose Veins  
Heart Condition  
Blood Clots/Phlebitis  
Diabetes  
Swelling  
Other \_\_\_\_\_

**DIGESTIVE SYSTEM**

Ulcers  
Irritable Bowel Syndrome  
Colitis  
Gallstones  
Hepatitis  
Crohn's Disease  
Diarrhea  
Gas/Bloating  
Indigestion  
Bleeding  
Constipation  
Difficulty swallowing  
Other \_\_\_\_\_

**SKIN**

Fungal infections  
Acne  
Impetigo  
Dermatitis/Eczema  
Psoriasis  
Open Wound or Sore  
Rashes  
Warts/Moles

Athlete's Foot  
Other \_\_\_\_\_

**RESPIRATORY SYSTEM**

Pneumonia  
Sinusitis  
Asthma  
Trouble breathing  
Dizziness  
Other \_\_\_\_\_

**MUSCULOSKELETAL SYSTEM**

Fibromyalgia  
Spasms/Cramps  
Sprains/Strains  
Osteoporosis  
Postural Deviations  
Gout  
Osteoarthritis/Rheumatoid  
Arthritis  
TMJ  
Cysts  
Bursitis  
Plantar Fasciitis  
Tendonitis  
Torticollis  
Whiplash Syndrome  
Carpal Tunnel Syndrome  
Sciatica  
Thoracic Outlet Syndrome  
Leg Pain  
Arm Pain/Shoulder Pain  
Low Back Pain  
Mid Back Pain  
Hip Pain  
Other \_\_\_\_\_

**NERVOUS SYSTEM**

ALS  
Multiple Sclerosis  
Parkinson's disease  
Bell's palsy  
Neuritis  
Spinal Cord Injury  
Stroke  
Trigeminal Neuralgia  
  
Numbness/Tingling/Twitching  
g  
Other \_\_\_\_\_

**OTHER**

Insomnia  
Sleep Apnea  
Anxiety/Panic Attacks  
Physical/Emotional Abuse  
Substance Abuse  
Grief Process  
Cancer  
Chronic Fatigue Syndrome  
HIV/AIDS  
Lupus  
Kidney Disease  
Bladder Infection  
Postoperative situation  
Depression  
Migraines  
Frequent headaches  
Ear/Nose/Throat infection  
Glaucoma  
Vision problems  
Other \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications, or manipulate bones. I further understand that massage therapy is not a substitute for medical attention and examination. I take full responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) may be charged in full for the price of the missed session.