Health Information

Client Contact Information

Client Name: ____ Date:___________

Date of Birth: _____________________________
Address:____
Phone: __________________________________ Email:______________________
Referred by:_______________________________
Emergency contact:_________________________ Phone:_____________________
Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes ☐ No ☐
Do you have a physician referral/prescription? Yes ☐ No ☐

Massage Information

What are your goals/expected outcomes for receiving massage/bodywork?__________

Do you have any conditions or are you taking any medications that require light pressure? ____

Are there any sites to avoid?____

Do you have any position restrictions?____

Description of injury/health condition:____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):____

Do these symptoms interfere with your activities of daily living? Yes No
Explain:____

Do you have any special needs or concerns?_________________________________

____

List the medications you are currently taking:____________________________________

____

____

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment?

____

Circle any of the following health conditions that you currently have:
blood clots, DVT, congestive heart failure, pitted edema,
infections, contagious diseases, renal failure
Please answer honestly, as massage may not be indicated for the above conditions.

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

Current Past Muscle or joint pain
Current Past Muscle or joint stiffness
Current Past Numbness or tingling
Current Past Swelling
Current Past Bruise easily
Current Past Sensitive to touch/pressure
Current Past High/Low blood pressure
Current Past Stroke, heart attack
Current Past Varicose veins
Current Past Shortness of breath, asthma
Current Past Cancer--please indicate what kind of cancer:
What kind of treatment? ___________________________________
When did treatment end?___________________________________
Did you have lymph nodes removed, or where they radiated?_____Where? _________
Current Past Neuropathy
Current Past Neurological (e.g. MS, Parkinson's, chronic pain)
Current Past Epilepsy, seizures
Current Past Headaches, Migraines
Current Past Dizziness, ringing in the ears
Current Past Digestive conditions (e.g. Crohn's, IBS)
Current Past Gas, bloating, constipation
Current Past Kidney disease, infection
Current Past Arthritis (rheumatoid, osteoarthritis)
Current Past Osteoporosis, degenerative spine/disk
Current Past Scoliosis

Current	Past	Broken bones
Current	Past	Blood clots
Current	Past	Allergies

If yes, what kinds of allergies?
Are you allergic to any kinds of oils or scents?

Current	Past	Diabetes
Current	Past	Endocrine/thyroid conditions
Current	Past	Depression, anxiety
Current	Past	Memory Loss, confusion, easily overwhelmed

Comments:

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. Understanding all of this, I give my consent to receive care.

Client Signature:____ Date:___________