

# Confidential Client Health History

## Client Information

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Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Zipcode: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Would you like to receive occasional newsletters or specials via email? Yes No

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

Primary Care Physican: \_\_\_\_\_ Phone: \_\_\_\_\_

May I contact if necessary with your permission? Yes No \_\_\_\_\_ (please initial if yes)

Occupation: \_\_\_\_\_ Referred by: \_\_\_\_\_

## Massage Experience

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1. What is your reason for seeking therapeutic massage?

*Relaxation Wellness Medical referral Injury Other*

Please describe: \_\_\_\_\_

2. Have you had a therapeutic massage before? Yes No Please describe types and frequency:

\_\_\_\_\_

3. Do you often feel stressed? Yes No To what degree? *Extreme High Average Low*

4. Do you like music during your massage session? Yes No

What types? *Relaxation Classical Jazz Nature New Age Other* \_\_\_\_\_

5. What kind of pressure do you prefer? *Light Medium Firm*

6. Are you sensitive to touch or pressure in any area? Yes No \_\_\_\_\_

## Current Health

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7. Do you perform repetitive moment in your work, sports or hobbies? Do you sit for long periods of time? Yes No Please describe: \_\_\_\_\_

\_\_\_\_\_

8. Do you exercise regularly? Yes No Please describe types and frequency: \_\_\_\_\_

\_\_\_\_\_

9. Are there any areas of your body where you tend to experience chronic pain, soreness, tension or stiffness? Yes No Please describe: \_\_\_\_\_
10. Are you currently under the care of a physician? Yes No If yes, explain: \_\_\_\_\_
11. What treatments or therapies are you currently undergoing? \_\_\_\_\_

**If you answer "yes" to any of the following questions, please explain.**

- |        |                                     |        |   |
|--------|-------------------------------------|--------|---|
| Yes No | Do you have a cold or flu?          | Yes No | Are you pregnant? Due date: _____                 |
| Yes No | Do you have any infections?         | Yes No | Do you have any contagious diseases?              |
| Yes No | Do you Have a fever?                | Yes No | Do you have high blood pressure?                  |
| Yes No | Do you wear contact lenses?         | Yes No | Are you taking HBP medication?                    |
| Yes No | Do you have any bruises?            | Yes No | Do you have diabetes?                             |
| Yes No | Do you have any open cuts?          | Yes No | Do you get blood clots?                           |
| Yes No | Do you have any skin rashes?        | Yes No | Do you have heart disease?                        |
| Yes No | Do you have any contact allergies?  | Yes No | Do you have varicose veins?                       |
| Yes No | Do you have eczema or psoriasis?    | Yes No | Do you have cancer?                               |
| Yes No | Do you have muscle pains?           | Yes No | Chemotherapy or radiation therapy?<br>Date: _____ |
| Yes No | Do you have scoliosis?              | Yes No | Do you have kidney disease?                       |
| Yes No | Do you have herniated discs?        | Yes No | Do you have lupus?                                |
| Yes No | Do you have any dislocated joints?  | Yes No | Have you had a stroke?                            |
| Yes No | Do you have bursitis or tendonitis? | Yes No | Do you suffer from epilepsy/ seizures?            |
| Yes No | Do you have any sprains or strains? | Yes No | Numbness or stabbing pains?                       |
| Yes No | Do you have osteoporosis?           | Yes No | Cortisone injection Date: _____                   |
| Yes No | Do you have fibromyalgia?           | Yes No |   |

Describe your overall health, any injuries/ surgeries and the dates they occurred. Please advise me of any pins, screws or artificial joints:

List all current medication(s) and condition(s) being treated:

*The information I have provided is accurate and complete to the best of my knowledge.*

*I understand that massage therapists do not diagnose or treat disease, and that any care or recommendation I receive from my therapist is not a substitute for a physician's care. I take responsibility for alerting my therapist of any changes to my health status, medications and therapies before the session, as well as any and all responses perceived to be a result of massage therapy as soon as I become aware of them.*

*I understand that no sexual activity, comment or innuendo will be tolerated.*

*I understand that it is the right of the massage therapist to refuse services at its discretion based upon the client's conditions, therapist's skill set, client attitude or action, etc., without explanation or prior notice, and I agree to this policy.*

**Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_**