

Client Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

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

Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_

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

**Health Information**

Primary Health Care Provider \_\_\_\_\_ Phone \_\_\_\_\_

*I give my practitioner permission to consult with my health care provider regarding my health and treatment.*    Initials \_\_\_\_\_ Date \_\_\_\_\_ Comments \_\_\_\_\_

Conditions currently being monitored by your health care provider

Medications taken today (include pain relievers & herbal remedies)

Other medications taken in the last 3 months

Have you had any of the following: (please include year and treatment received):  
Surgeries

Injuries/accidents still affecting you

Major illnesses or other hospitalizations

List primary stress reduction activities and frequency:

**Treatment Information**

Have you ever received professional bodywork?    Yes    No    Approx. date of last massage

Have you ever received energy work?    Yes    No

What is your intention for this session/What results do you want from your session?

If you are receiving bodywork, are there any areas of your body for which you do NOT want massage?  
(Note: Breasts/genitals will never be touched.)

Please mark any of the following that you have now or have had in the past. Circle applicable condition where two are listed on the same line, and indicate right or left side where appropriate.

Now	Past	Condition	Now	Past	Condition
		<b><u>Nervous System</u></b>			<b><u>Musculoskeletal</u></b>
		Shingles			Bone or joint disease
		Numbness/Tingling			Tendonitis/bursitis
		Trigeminal Neuralgia			Arthritis/gout
		Bell's Palsy			Scoliosis
		Sciatica			Spinal problems
		Pinched nerve			Disk problems
		Head injuries/concussions			Sprains/strains
		Loss of memory/confusion			Low back/ hip / leg pain
		Other			Neck/ shoulder/ arm pain
					Spasms/cramps
		<b><u>Circulatory</u></b>			Jaw pain/TMJ
		Heart condition			Lupus
		Chest pain/shortness of breath			Osteoporosis
		Phlebitis/varicose veins			Stiff or painful joints
		Blood clots			Other
		High/low blood pressure			
		Lymphedema			<b><u>Endocrine</u></b>
		Thrombosis/embolism			Thyroid dysfunction
		Stroke			Diabetes
		Poor circulation			Other
		Other			
					<b><u>Digestive/Elimination</u></b>
		<b><u>Respiratory</u></b>			Constipation/diarrhea
		Breathing difficulty			Gas/bloating
		Asthma			Diverticulitis
		Allergies			Irritable bowel syndrome
		Sinus problems			Ulcers
		Other			Bladder or kidney problems
					Abdominal pain
		<b><u>Skin</u></b>			Other
		Allergies			
		Rashes			<b><u>Other/General</u></b>
		Herpes/cold sores (current)			Cancer/tumors
		Athlete's foot			If yes, were lymph nodes removed or irradiated?
		Warts (current)			Fibromyalgia
		Infections (current)			Communicable disease (current—specify)
		Other			Inflammation/swelling (current)
					Fever or infection (current)
		<b><u>Reproductive</u></b>			Chronic fatigue
		Pregnant Stage			Sleep disturbances
		Ovarian/menstrual problems			Headaches Type
		PMS			Chronic pain
		Prostrate problems			Depression/anxiety/stress (circle)
		Other			Contact lenses

I give my consent to receive massage therapy and/or energy work. I have listed all my known medical conditions and physical limitations and will inform my therapist of any changes. I understand: 1) that a massage therapist must be aware of all existing physical conditions in order to provide medically safe massage; 2) that a massage therapist neither diagnoses nor prescribes for any medical, physical or emotional disorder, nor performs any thrusting joint or spinal manipulations; 3) that all treatments are intended to be complements to rather than substitutes for medical advice and treatment; 4) and that I am responsible for consulting a qualified primary care provider for any physical or emotional ailments, concerns, or issues that I may have. I agree to give 24 hours notice if I must cancel an appointment.

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

Signature of parent/guardian (if client is a minor) \_\_\_\_\_ Date \_\_\_\_\_