CLIENT HEALTH INFORMATION SHEET

PERSONAL DATA:

Name: _____ Date: _____

Birthday: _____ Phone (home):_____

Address: _____ Phone (cell): _____

City/State/Zip: _____

Primary Health Care Provider: _____ Phone: _____

Permission to consult with primary provider? _____ Yes _____ No

Who referred you to this office? _____

Advertisement: _____ Sign: _____ Other: _____

MASSAGE HISTORY/TREATMENT INFORMATION

* Have you ever received a professional massage? _____ Yes _____ No

* Preferred massage treatment product. ____ Lotion ____ Oil ____ Aromatherapy

* What are your intentions/expectations for this visit? _____
_____

* What type of pressure do you prefer? _____ Light _____ Medium _____ Deep

* Please check the areas of your body that you give permission to receive massage:
__ Back __ Legs __ Arms __ Neck __ Head __ Face __ Buttocks __ Abdomen

CURRENT MAJOR COMPLAINT INFORMATION

(If you do not have current health concerns, please go to health history section)

* Present symptoms: What is your major complaint or condition that you want to improve?
_____
_____

* When did you first notice major complaints? _____

* What activities aggravate the condition? _____

* What activities alleviate the condition? _____

* Is this condition getting progressively worse? _____ Yes _____ No
Please explain _____

* Does this condition interfere with:
Work? ___ Yes ___ No Sleep? ___ Yes ___ No Daily routine? ___Yes ___ No
Please explain: _____

* What have you done to get relief? _____

* Has there been a medical diagnosis? ___ Yes ___ No

If so, by whom? _____
Please explain _____

HEALTH HISTORY

* Are you now under medical/therapeutic treatment? ___ Yes ___ No
If yes, for what condition? _____

* List any medications (including aspirin) and nutritional supplements you are taking:
_____

* List stress reduction and exercise activities. Include frequency: _____
_____

* Please list (date and description) any accidents or operations: _____
_____

MUSCULO-SKELETAL

___ Bone or joint disease _____
___ Tendonitis _____
___ Bursitis _____
___ Broken/fractured bones _____
___ Arthritis _____
___ Sprains/strains _____
___ Low back,hip,leg pain _____
___ Neck,shoulder,arm pain _____
___ Headaches/head injuries _____
___ Spasms/cramps _____
___ Jaw pain/ TMJ _____
___ Lupus _____
___ Other _____

SKIN

___ Allergies _____
___ Rashes _____
___ Athlete's foot _____
___ Warts _____
___ Other _____

DIGESTIVE

___ Constipation
___ Gas/bloating
___ Diverticulitis
___ Irritable bowel syndrome ____
___ Other _____

CIRCULATORY

___ Heart condition _____
___ Varicose veins _____
___ Blood clots _____
___ High blood pressure _____
___ Low blood pressure _____
___ Lymphedema _____
___ Breathing difficulty _____
___ Sinus problems _____
___ Allergies _____
___ Other _____

NERVOUS SYSTEM

___ Herpes/shingles _____
___ Numbness/tingling _____
___ Chronic pain _____
___ Fatigue _____
___ Sleep disorders _____
___ Other

REPRODUCTIVE

___ Pregnant? Stage _____
___ PMS _____

AUTO IMMUNE/INFECTIOUS DISEASE

___ Fibromyalgia _____
___ Chronic fatigue _____
___ Rheumatoid arthritis _____
___ Lupus _____
___ Epstien Barr _____
___ Other _____

OTHER

___ Cancer/tumors _____
___ Diabetes _____
___ Eating disorders _____
___ Depression _____
___ Drug/alcohol addiction _____
___ Nicotine/caffeine addiction ____

It is my choice to receive massage treatment. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time that I feel like my well-being is being compromised.

I understand that massage practitioners do not diagnose illness, disease or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health.

Signature: _____ Date: _____