MASSAGE THERAPY
Confidential Client History

NAME: ___________________________Nickname:_______________ Birth Date: ____________
Address: ____ City____________________________
State_________________ Zip Code_______________ Phone: ______________________________
Occupation: ____ (if retired, what was your occupation)
What are the physical requirements of your job? ____
____
Family Physician: ___________________________________Phone Number: ________________
Email Address_______________________________________ Cell Phone: ____________________
Have you had a professional massage before? [ ] YES [ ] NO
What benefits would you like to receive from this massage? _______________________________
____
Do you have any skin problems or skin allergies? [ ] YES [ ] NO _____________________
Do you take any medication(s)? [ ] YES [ ] NO If yes, list here: _______________________
____
Do you have any allergies? [ ] YES [ ] NO (medications, perfumes, foods)
If so, list here: ____
Have you suffered an acute injury recently? [ ] YES [ ] NO ___________________
Have you had any broken bones in the last 2 years? [ ] YES [ ] NO ___________________
Do you have any varicose veins or blood clots? [ ] YES [ ] NO ____________________
Do you exercise regularly or partake in sports? [ ] YES [ ] NO ____________________
Have you had any joint replacement surgeries? [ ] YES [ ] NO ____________________
Do you take any medications that thin your blood? [ ] YES [ ] NO ____________________
Are you sensitive to touch or pressure in any area? [ ] YES [ ] NO ____________________

Do you have difficulty with any of the following:

__Anemia
__Asthma
__Arthritis
__Bladder Trouble
__Cancer
__Chest pains
__Depression
__Diabetes
__Dizziness
__Epilepsy/seizures
__Fatigue
__Back Problems
__Gallbladder
__Headaches
__High blood pressure
__History of Heart problems
__HIV
__Indigestion
__Kidney trouble
__Liver trouble
__Loss of balance
__Low blood pressure
__Osteoporosis
__Pregnancy
__Pains in legs/feet
__Painful, swollen joints
__Pins/needles in arms/hands
__Pins/needles in legs
__Ringing in ears
__Sinus trouble
__Sleeping problems
__Slipped disc
__Stomach trouble
__Thyroid trouble
__MRSA
__Other____________________

PLEASE READ THE FOLLOWING CAREFULLY AND THEN SIGN

I, ______________________________, understand that massage therapy given here is for the purpose of relaxation and relief from muscular tension or spasm. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. I also understand that the massage therapist does not prescribe medical treatment, medications, nor perform spinal manipulation. It has been made clear to me that massage is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see my medical doctor for any physical ailment that I may have. To my knowledge I have adequately informed the massage therapist of any existing medical conditions and take it upon myself to keep the massage therapist updated on my health status.

If I experience any pain or discomfort during the massage session I will advise the massage therapist so that the technique(s) may be adjusted to my comfort level.

It is also understood that any illicit or sexually suggestive remarks or advances by me will result in immediate termination of the session, and I will be liable for payment of the scheduled session.

____Date ______________________
Client's signature

____Date ______________________
Massage Therapist's signature