CONFIDENTIAL CLIENT HISTORY

LEASE PRINT CLEARLY

DATE:_____

NAME:_____

REFERRED BY:_____

ADDRESS:_____

PHONE-DAY:_____

_____

PHONE-EVE:_____

BIRTHDATE:_____

AGE:_____

OCCUPATION:_____

EMPLOYER:_____

HOW DO YOU PREFER TO BE ADDRESSED? MR./MRS./MS./DR./FIRST NAME (CIRCLE ONE)

MASSAGE/ CASE HISTORY

REASON(S) THAT YOU ARE REQUESTING MASSAGE THERAPY :

_____

_____

HAVE YOU EVER RECEIVED A PROFESSIONAL MASSAGE?_____YES_____NO

IF YES, FREQUENCY:_____

DATE OF LAST MASSAGE:_____

PRIORITIZE THE AREAS OF YOUR BODY THAT YOU WOULD PREFER TO HAVE MASSAGED:

_____

_____

DO YOU WEAR CONTACT LENSES?_____YES _____NO

ARE YOU PREGNANT?_____YES _____NO

ARE YOU CURRENTLY SEEING A MEDICAL/CHIROPRACTIC PRACTITIONER?_____YES_____NO

PLEASE EXPLAIN IF YES:

_____

_____

ARE YOU ON ANY MEDICATIONS (PRESCRIPTION OR OVER-THE-COUNTER)?

_____

ARE YOU CURRENTLY UNDER STRESS?_____

ARE YOU CURRENTLY EXPERIENCING EMOTIONAL DIFFICULTIES?_____

LIST ANY SURGERIES OR INJURIES:

SURGERIES:_____

_____

INJURIES:_____

_____

_____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING? PLEASE CHECK IF "YES."

MUSCULOSKELETAL:
_____Bone or joint disease
_____Arthritis
_____Sprains/strains
_____Low back pain
_____Upper back/mid-back pain
_____Hip/leg pain
_____Neck pain
_____Shoulder/arm pain
_____Headaches
_____Jaw pain/clicking/popping
_____Clenching or grinding teeth
_____Spasms/cramps
_____Spinal curvature
_____Fibromyalgia
_____Other_____
___ OSTEOPOROSIS

DIGESTIVE:
_____Constipation
_____Gas/bloating
_____Hiatal hernia
_____Other_____

RESPIRATORY/CIRCULATORY:
_____High blood pressure
_____Breathing difficulties
_____Varicose veins
_____Other cardiovascular problems
_____Other_____

SKIN:
_____Rashes
_____Bruising easily
_____Sensitive skin
_____Hives/allergies
_____Other_____
___ATHLETE'S FOOT (CURRENTLY)

NEUROLOGICAL:
_____Herpes/shingles
_____Numbness/tingling
_____Chronic pain
_____Dizziness (any cause)
_____Other_____

GENITOURINARY:
_____Kidney infections
_____Kidney stones
_____Prostate problems
_____Other_____

FOR WOMEN ONLY:
_____Painful menstruation
_____Yeast infections
_____Breast lumps/masses
_____Other_____

OTHER:
_____Allergies(any)
_____Sinus problems
_____Cancer/tumors
_____Fatigue
_____Difficulty sleeping
_____Diabetes
_____Drug/alcohol addiction
_____Nicotine/caffeine addiction
_____Other_____

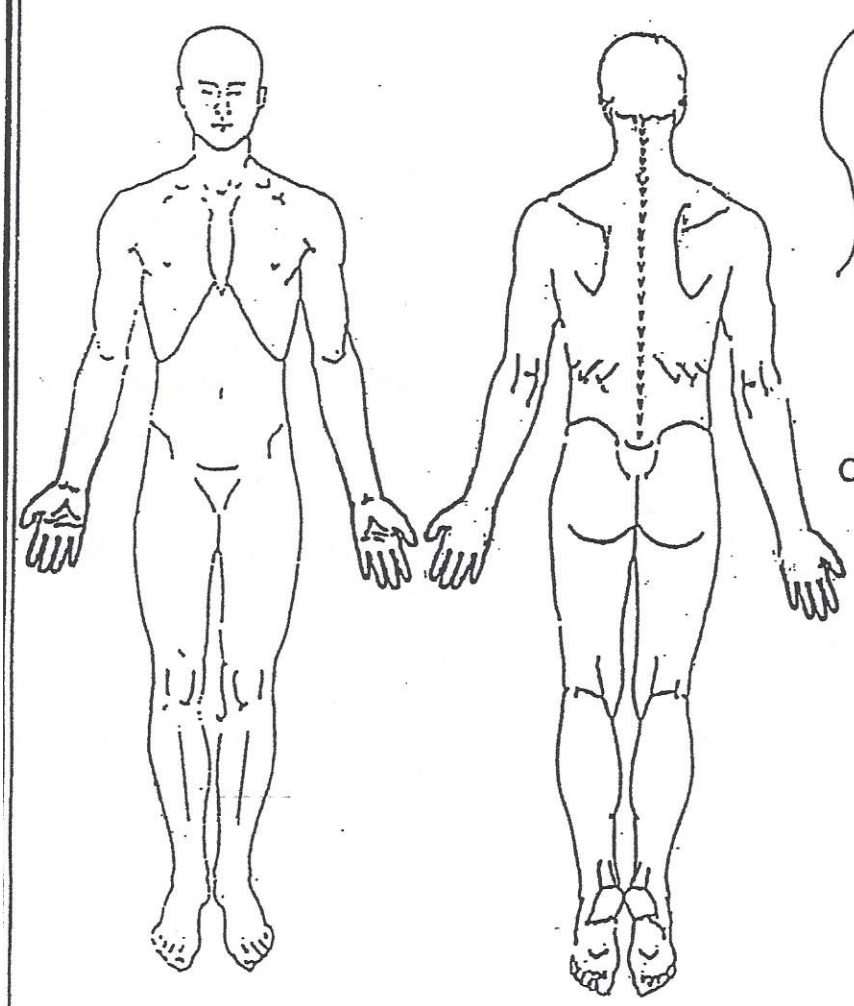
INFECTIOUS DISEASE:
_____Disease name(s)
_____

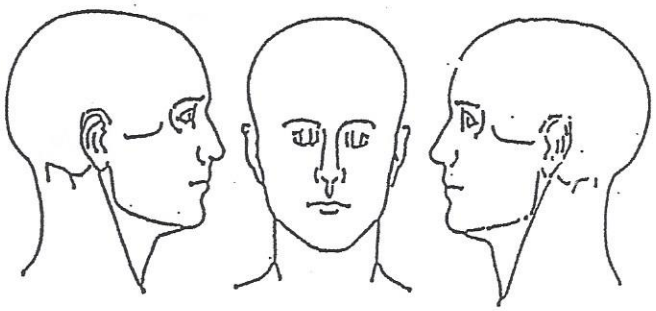
What do you want to accomplish in today's session? _____

Do you now have any of the following?

☐ irritated skin rash ☐ open cuts, bruises, burns ☐ sunburn ☐ inflammation

Please indicate below the places you are feeling discomfort:





Comments:

I understand this massage is not a replacement for medical care and that no diagnosis will be made. I freely give my permission for the therapy received.

Date _____ Signature _____

◆◆ *Your appointment time has been set aside just for you!* ◆◆

If you find it necessary to reschedule,
please give notice 24 hours in advance
so you will not be charged.