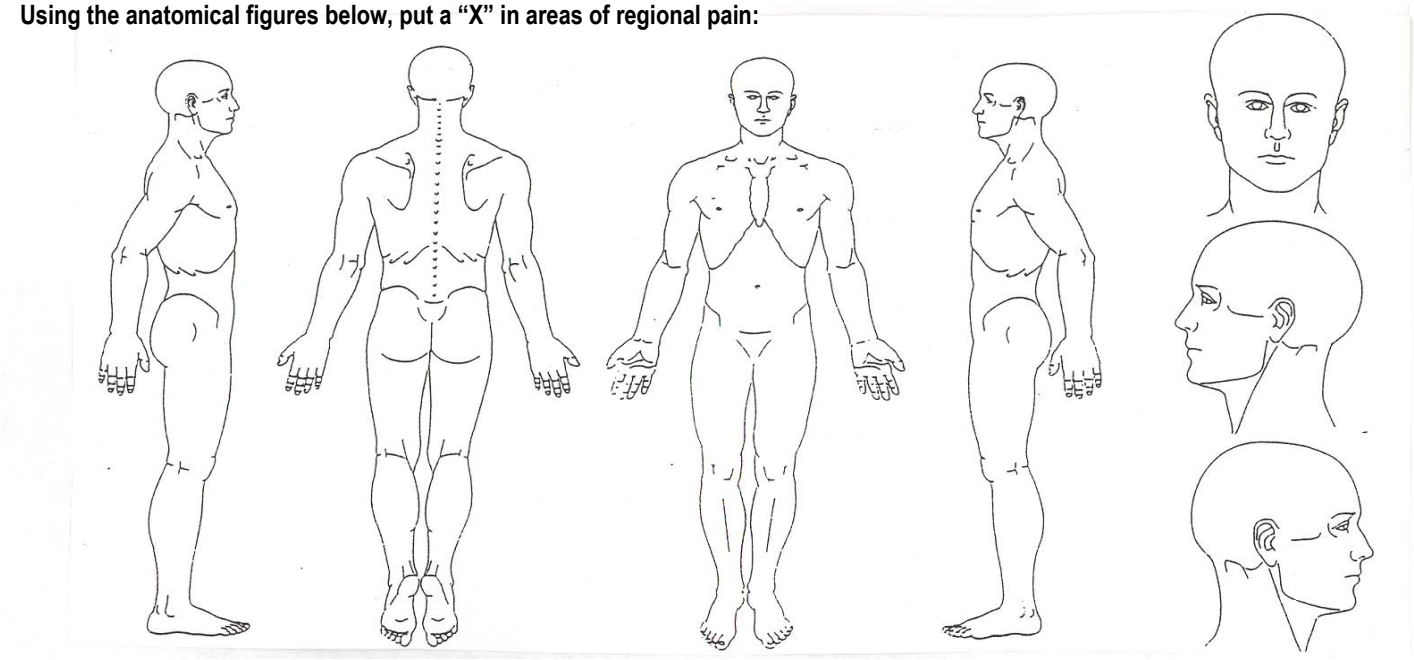
Massage Therapy Client Information

Last Name_____ First Name_____ Occupation_____
Address _____
Phone_____ Email_____ Ht_____ Wt_____ circle: M F
Birthdate_____ How did you learn about our services? _____

Medical History
Are you currently under a physician's care for anything I need to be aware of?_____
Surgeries/dates_____
Diagnosed with illness, disease in the last two years (describe)_____ pregnant?_____
Been in a car accident or suffered trauma to your body/dates _____
Bruise easily_____"brittle bones"_____ broken bones/dates_____
Physical therapy/dates_____ high/low blood pressure_____ diabetes_____
Skin allergies, skin condition, skin lesions or wounds (describe)_____
Have you ever received radiation therapy?____chemotherapy?____other?_____
Name all prescribed and over-the-counter medications including herbs & supplements you take and for what reason _____
_____
(Massage can increase your body's absorption of these products.)

Pain History
Are you currently experiencing pain in your joints or muscles?___ Describe your pain and its location _____
_____
How long have you experienced this pain? _____ What makes it worse?_____
What makes it better?_____ Have you used heat or cold packs? _____
Does this pain affect your ability to work, play, exercise?_____ In what way? _____
What do you think may have caused this pain?_____

Using the anatomical figures below, put a "X" in areas of regional pain:



Do you regularly allow relaxing time-out for yourself?____ Do you believe this massage session will be helpful to you?____
Have you received a massage before?____ If yes, what type of pressure have you found to be most beneficial? _____
_____

Signature_____ Date_____

Massage Therapist's Notes

Date	Time	Updates on client's status, other comments	Signature