



### Contact Information

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Best Time To Call: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Hours Worked Per Week? \_\_\_\_\_ Do You Enjoy Your Work? \_\_\_\_\_  
Referred By: \_\_\_\_\_ How Did You Hear About Our Clinic? \_\_\_\_\_  
Emergency Contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Massage Information

First Professional Massage?: Yes No How Frequently Do You Receive Massage?: \_\_\_\_\_  
What Types/Modalities of Massage Have you Received?: \_\_\_\_\_

### Medical Information

List major accidents/injuries, hospitalizations, and surgeries in the last 5 years...

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently under the care of a physician? Please list all prescriptions, supplements, or herbs you taking and reason for taking them.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Medical History

#### Musculoskeletal

- Arthritis
- Chronic Headaches
- Chronic Pain in:
  - Back
    - Upper-back
    - Mid-back
    - Lower-back
  - Neck
- Fibromyalgia
- Osteoporosis
- Tendonitis
- Whiplash

#### Respiratory

- Asthma
- Breathing Problems

#### Circulatory

- Heart Problems
- Hemophilia
- Low/High Blood Pressure
- Stroke
- Varicose Veins

#### Skin

- Athlete's Foot
- Eczema/Dermatitis
- Psoriasis
- Easily Irritated Skin

#### Nervous System

- Dizziness
- Multiple Sclerosis
- Seizures/Epilepsy

#### Other

- Anxiety/Panic Attacks
- High Stress
- PMS/Menopause Difficulties
- Poor Sleep/Insomnia
- Postoperative:
- Pregnancy/ Weeks:
  - Due Date: \_\_\_\_\_
  - Complications/Concerns \_\_\_\_\_

Any issues not listed above? Please Describe: \_\_\_\_\_  
\_\_\_\_\_

### Exercise

Activities: \_\_\_\_\_ Number of times/days per week: \_\_\_\_\_

To the best of my knowledge, the above information is accurate. I understand that Massage Therapists do not diagnose disease or prescribe drugs and that massage is not a substitute for medical care. I agree to alert my practitioner of any physical/emotional changes as they occur. I also understand that I will be charged a \$25 fee for any NSF checks and \$50 for appointments not canceled at least 24 hrs in advance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Parent/Guardian if Client is a Minor: \_\_\_\_\_ Date: \_\_\_\_\_  
Client's Name Printed: \_\_\_\_\_ Parent/Guardian's Name Printed: \_\_\_\_\_

*Please Advise Us if You Are Ill Today. We Will Need to Reschedule Your Massage.*