Health Information

Client Name: _____ Date: _____
Address:_____Date of Birth: _____
_____
Phone: _____ Is it OK to text this number Yes ☐ No ☐
Email address: _____ Profession:_____
Referred by: _____
Are you a veteran, active military or First Responder? Yes ☐ No ☐

Emergency contact: _____ Phone: _____

Have you ever received professional massage/bodywork before? Yes ☐ No ☐
How recently? _____
How frequently? _____
What types of massage/bodywork do you prefer? _____
What kind of pressure do you prefer? Light Medium Firm
What are your goals/expected outcomes for receiving massage/bodywork?
_____
_____
List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):
_____
_____
_____
Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No Explain:
_____
_____
List the medications you currently take:
_____
_____
_____
Are you wearing contacts? Yes ☐ No ☐
Are you pregnant? Yes ☐ No ☐

Have you had any injuries or surgeries in the past that may influence today's treatment?
_____
_____
_____
_____
_____

-OVER-

Health Information

Circle any of the following health conditions that you currently have (If you are unsure, please ask): **blood clots, infections, congestive heart failure, contagious diseases, pitted edema**
Please answer honestly, as massage may not be indicated for the above conditions.
Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

Current Past Muscle or joint pain _____
Current Past Muscle or joint stiffness _____
Current Past Numbness or tingling _____
Current Past Swelling _____
Current Past Bruise easily _____
Current Past Sensitive to touch/pressure _____
Current Past High/Low blood pressure _____
Current Past Stroke, heart attack _____
Current Past Varicose veins _____
Current Past Shortness of breath, asthma _____
Current Past Cancer _____
Current Past Neurological (e.g. MS, Parkinson's, chronic pain) _____
Current Past Epilepsy, seizures _____
Current Past Headaches, Migraines _____
Current Past Dizziness, ringing in the ears _____
Current Past Digestive conditions (e.g. Crohn's, IBS) _____
Current Past Gas, bloating, constipation _____
Current Past Kidney disease, infection _____
Current Past Arthritis (rheumatoid, osteoarthritis) _____
Current Past Osteoporosis, degenerative spine/disk _____
Current Past Scoliosis _____
Current Past Broken bones _____
Current Past Allergies _____
Current Past Diabetes _____
Current Past Endocrine/thyroid conditions _____
Current Past Depression, anxiety _____
Current Past Memory Loss, confusion, easily overwhelmed _____

Comments:

_____
_____
_____
_____
_____
_____