

MASSAGE THERAPY CLIENT HISTORY

All information disclosed is confidential and will be used for no other purpose than to provide the massage therapist with a better understanding of the client's picture.

Name: _____ Date: _____

Address: _____ Res. #: _____

_____ Postal Code: _____ Bus. #: _____

Weight: _____ Height: _____ D.O.B. _____ Gender: _____

Occupation: _____ Family Physician: _____

Exercise / Sports Activities: _____

Hobbies / Recreational Activities: _____

How did you find out about the massage therapist / clinic? _____

Medication: _____ Condition: _____

SURGERIES, PAST INJURIES, MOTOR VEHICLE ACCIDENTS?

Type: _____ Date: _____ Treatment: _____

PLEASE CHECK ANY CONDITION YOU PRESENTLY EXPERIENCE OR HAVE EXPERIENCED IN THE PAST:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Allergies/sensitivities | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hormone deficiencies | <input type="checkbox"/> Numbness/tingling |
| <input type="checkbox"/> Ankle/foot pain | <input type="checkbox"/> Elbow pain | <input type="checkbox"/> Infectious disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Kidney/bladder disorder | <input type="checkbox"/> Pulled/strained muscles |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Knee pain | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Bone Infection | <input type="checkbox"/> Fluid retention | <input type="checkbox"/> Lower leg/calf pain | <input type="checkbox"/> Shin splints |
| <input type="checkbox"/> Calcium dep./bone chips | <input type="checkbox"/> Fractures | • during activity ____ | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> Cancer/tumors | <input type="checkbox"/> Hand pain | • at rest ____ | <input type="checkbox"/> Skin conditions |
| <input type="checkbox"/> Carpal tunnel syndrome | <input type="checkbox"/> Headaches | <input type="checkbox"/> Menopause | <input type="checkbox"/> Sprain(s) |
| <input type="checkbox"/> Cold intolerance | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depression/anxiety | <input type="checkbox"/> Hernia | <input type="checkbox"/> Muscle spasms/cramps | <input type="checkbox"/> Torn ligaments |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herniated disk | <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Upper leg pain |
| <input type="checkbox"/> Diet/nutritional concerns | <input type="checkbox"/> Hi/lo blood pressure | <input type="checkbox"/> Nausea | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Digestive disorders | <input type="checkbox"/> Hip/buttock pain | <input type="checkbox"/> Nerve damage | <input type="checkbox"/> Whiplash |
| | | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Wrist pain |

Please explain any other condition not listed above: _____

SENSORY AIDS, PROSTHESIS, ORTHOTICS?

- Dentures
- Pins / Plates
- Heel Lifts
- Other _____
- Artificial Limbs / Joints
- Splints / Brace

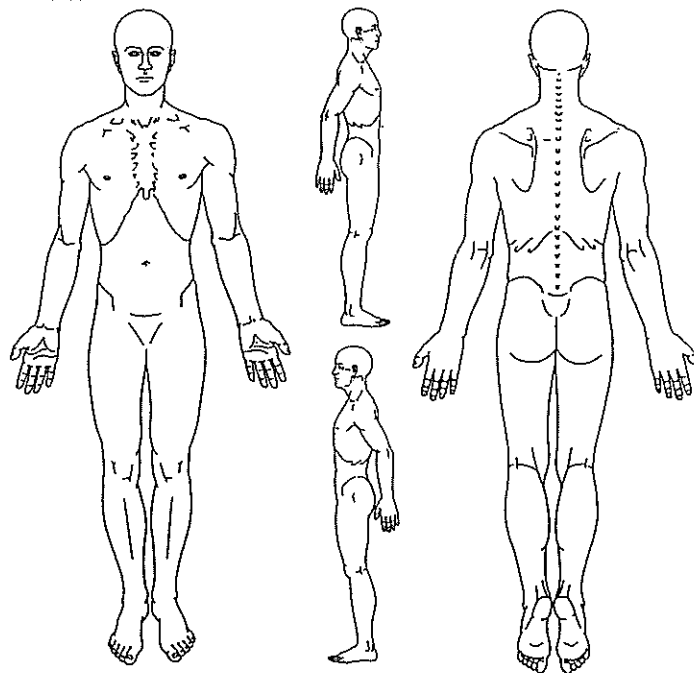
PRESENT SYMPTOMS: What is your major complaint? _____

MINOR COMPLAINTS: Other areas of concern. _____

What aggravates your symptoms? _____

What relieves your symptoms? _____

Indicate areas of pain, tingling and numbness.



I understand that massage therapy is an asset to my health, but does not take place of any medical care my physician may recommend. I have given the correct information regarding my health and am not aware of any reasons for not having massage therapy.

Client's Signature: _____

Date: _____

MASSAGE THERAPY CANCELLATION POLICY

A cancellation of scheduled appointments is required and enforced in our clinic. A patient is required to give **TWENTY-FOUR HOURS NOTICE** to cancel or change an appointment time. Without the 24-hour notice, the full cost of Massage Therapy treatment will be charged to you.

I hereby authorize and grant permission to the Massage Therapist in charge of my treatment and the clinic to employ such policy.

_____ I understand that a “**no show**” appointment will result in the **PATIENT** being charged for the cost of the Massage Therapy treatment, and that these appointments will **NOT** be covered by personal insurance.

DATE: _____ Patient Name (printed): _____

Patient Signature: _____