



Massage Client Health Information

FIRST: _____

LAST: _____

ADDRESS: _____ CITY: _____ ZIP: _____

DOB: _____ PHONE: _____

EMAIL: _____

HOW DID YOU HEAR ABOUT OUR SERVICES? _____

*IF YOU ANSWER **YES** TO ANY OF THE FOLLOWING QUESTIONS, PLEASE DISCUSS WITH YOUR THERAPIST.*

YES / NO

___ DO YOU FREQUENTLY SUFFER FROM STRESS?

___ DO YOU EXPERIENCE FREQUENT HEADACHES?

___ ARE YOU PREGNANT?

___ ARE YOU DIABETIC?

___ DO YOU HAVE HIGH BLOOD PRESSURE?

___ ARE YOU EPILEPTIC?

___ HAVE YOU HAD ANY RECENT SURGERIES?

___ HAVE YOU HAD ANY BROKEN BONES IN THE LAST TWO YEARS?

___ DO YOU HAVE TENSION OR SORENESS IN A SPECIFIC AREA?

___ DO YOU HAVE CARDIAC OR CIRCULATORY PROBLEMS?

___ DO YOU SUFFER FROM BACK PAIN?

___ DO YOU HAVE NUMBNESS OR STABBING PAINS?

___ ARE YOU SENSITIVE TO TOUCH/PRESSURE IN ANY AREA?

___ DO YOU HAVE ANY OTHER MEDICAL CONDITION I SHOULD BE AWARE OF?

WHAT SPECIFIC AREAS WOULD YOU LIKE ME TO FOCUS ON? WHAT SPECIFIC AREAS WOULD YOU LIKE ME TO AVOID?

If you have a specific medical condition or specific symptoms, massage work may be contraindicated. A referral from your primary care provider may be required prior to services being provided. I understand that the massage work I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. Because massage therapy is contraindicated under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile, and understand that there shall be no liability on the practitioner's part should I forget to do so.

Sign: _____ Date: _____