

The information requested below will assist us in providing you with safe treatments. Please ask your therapist if you have any questions about the information being requested. All information provided below will be kept as confidential unless allowed or required by law. Your written permission will be required to release any information.

Client Information

Name \_\_\_\_\_ Email \_\_\_\_\_  
 Phone (cell/day) \_\_\_\_\_ DOB \_\_\_\_\_ Age: \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_  
 Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_ Gender \_\_\_\_\_  
 Occupation \_\_\_\_\_ Referred by: \_\_\_\_\_

Health Information IF NO, FEEL FREE TO LEAVE BLANK

|                     |                                                          |                          |                                                          |                                                         |
|---------------------|----------------------------------------------------------|--------------------------|----------------------------------------------------------|---------------------------------------------------------|
| Anxiety / stress    | <input type="checkbox"/> yes <input type="checkbox"/> no | Muscle weakness          | <input type="checkbox"/> yes <input type="checkbox"/> no | <b>Notes:</b> _____<br>_____<br>_____<br>_____<br>_____ |
| Bleeding disorder   | <input type="checkbox"/> yes <input type="checkbox"/> no | Neuropathy               | <input type="checkbox"/> yes <input type="checkbox"/> no |                                                         |
| Blood clot          | <input type="checkbox"/> yes <input type="checkbox"/> no | Osteoarthritis           | <input type="checkbox"/> yes <input type="checkbox"/> no |                                                         |
| Bruise easily       | <input type="checkbox"/> yes <input type="checkbox"/> no | Osteoporosis             | <input type="checkbox"/> yes <input type="checkbox"/> no |                                                         |
| Bursitis            | <input type="checkbox"/> yes <input type="checkbox"/> no | Phlebitis/varicose veins | <input type="checkbox"/> yes <input type="checkbox"/> no |                                                         |
| Cancer / tumor      | <input type="checkbox"/> yes <input type="checkbox"/> no | Rheumatoid arthritis     | <input type="checkbox"/> yes <input type="checkbox"/> no |                                                         |
| Depression          | <input type="checkbox"/> yes <input type="checkbox"/> no | Sciatica                 | <input type="checkbox"/> yes <input type="checkbox"/> no |                                                         |
| Diabetes            | <input type="checkbox"/> yes <input type="checkbox"/> no | Seizures                 | <input type="checkbox"/> yes <input type="checkbox"/> no |                                                         |
| Fibromyalgia        | <input type="checkbox"/> yes <input type="checkbox"/> no | Stroke / CVA             | <input type="checkbox"/> yes <input type="checkbox"/> no |                                                         |
| Hearing loss        | <input type="checkbox"/> yes <input type="checkbox"/> no | Tuberculosis             | <input type="checkbox"/> yes <input type="checkbox"/> no |                                                         |
| High blood pressure | <input type="checkbox"/> yes <input type="checkbox"/> no | Tendinitis               | <input type="checkbox"/> yes <input type="checkbox"/> no |                                                         |
| Low blood pressure  | <input type="checkbox"/> yes <input type="checkbox"/> no | TMJ disorder             | <input type="checkbox"/> yes <input type="checkbox"/> no |                                                         |
| Kidney disease      | <input type="checkbox"/> yes <input type="checkbox"/> no | Vertigo / dizziness      | <input type="checkbox"/> yes <input type="checkbox"/> no |                                                         |
| Multiple sclerosis  | <input type="checkbox"/> yes <input type="checkbox"/> no | Vision impairment        | <input type="checkbox"/> yes <input type="checkbox"/> no |                                                         |

Any skin conditions? ☐ yes ☐ no \_\_\_\_\_  
 Neurological conditions? ☐ yes ☐ no \_\_\_\_\_  
 Heart condition? ☐ yes ☐ no \_\_\_\_\_  
 Autoimmune disorder? ☐ yes ☐ no \_\_\_\_\_  
 Digestive problem? ☐ yes ☐ no \_\_\_\_\_  
 Endocrine disorder? ☐ yes ☐ no \_\_\_\_\_  
 Respiratory disorder? ☐ yes ☐ no \_\_\_\_\_  
 Areas of swelling? ☐ yes ☐ no \_\_\_\_\_  
 Frequent headaches? ☐ yes ☐ no \_\_\_\_\_  
 Areas of numbness or decreased sensation? \_\_\_\_\_  
 Areas of broken skin? (e.g. rash, wounds) ☐ yes ☐ no If yes, where? \_\_\_\_\_  
 Any current infectious or contagious conditions? (e.g. HIV, TB, fungal infections, shingles, warts, etc.) ☐ yes ☐ no  
 If yes, please list: \_\_\_\_\_  
 Are you taking any medications? If yes, please list: \_\_\_\_\_

Any allergies or hypersensitivities? (oils, lotions, nuts, fruits, skin, etc.) ☐ yes ☐ no \_\_\_\_\_

Are you pregnant? ☐ yes ☐ no If yes, how many months: \_\_\_\_\_ Due date: \_\_\_\_\_

History of joint replacement surgery? ☐ yes ☐ no Which joint(s) ? \_\_\_\_\_

Any implants? (e.g. pacemaker, insulin pump, metal) ☐ yes ☐ no What, where? \_\_\_\_\_

Are you currently under medical supervision or receiving other medical interventions?

If yes, please describe: \_\_\_\_\_

Recent injuries or medical procedures in the past 2 years? ☐ yes ☐ no Please describe: \_\_\_\_\_

Please describe any other injuries or health conditions: \_\_\_\_\_

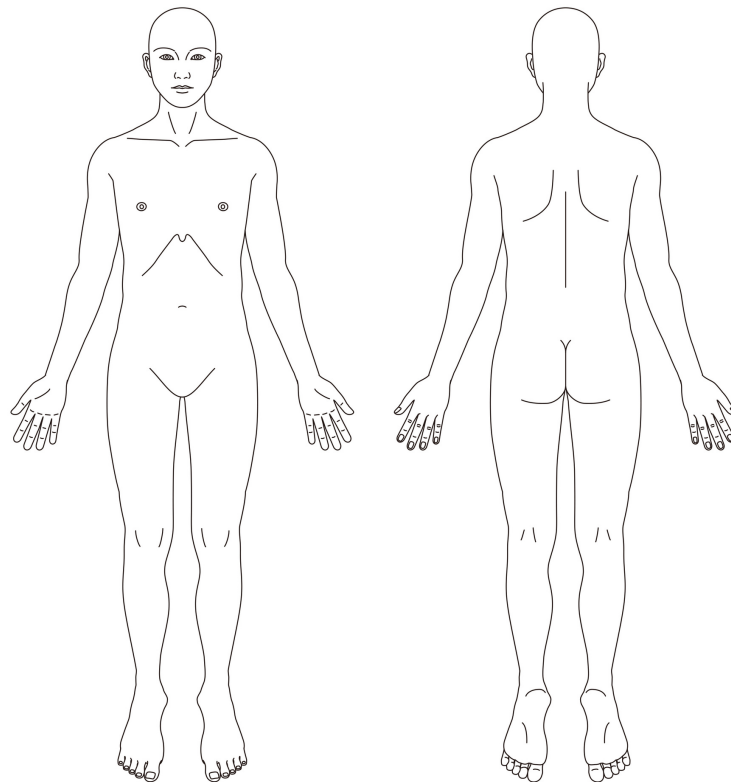
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Have you had professional massage before? ☐ yes ☐ no How recently? \_\_\_\_\_

Reason for seeking massage: ☐ Relaxation ☐ Specific problem \_\_\_\_\_

How much pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

*Please indicate any areas of pain or discomfort*



By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have completed this form accurately and truthfully to the best of my knowledge. I also agree to inform my massage therapist of any health or medical changes.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_