

CLIENT HISTORY

Name: _____

Date: _____

Address: _____

Phone: _____

DOB: _____

Email: _____

Occupation: _____ Emergency Name & Number: _____

How did you hear about us? _____

Have you ever experienced a professional massage or bodywork session? _____

Primary reason for appointment? _____

Please take a moment to carefully read and mark the following information as it applies to you. If you have specific medical conditions or symptoms, massage /bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> No Tension/Stress | <input type="checkbox"/> No Faigue | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Muscle or Bone Injuries | <input type="checkbox"/> Rotator Cuff Injury | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Numbness or Tingling | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Jaw Pain, TMJ | <input type="checkbox"/> Chronic Sinus Issues |
| <input type="checkbox"/> Allergy/Sensitivity | <input type="checkbox"/> Rashes, Athletes Foot | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Blood Clots/Phlebitis |
| <input type="checkbox"/> Spinal Column Disorders | <input type="checkbox"/> Asthma, Lung Conditions | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Digestive Problems/Disorders | <input type="checkbox"/> Hernia | <input type="checkbox"/> Lupus | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Wearing Contacts |
| <input type="checkbox"/> Wearing Dentures | <input type="checkbox"/> Grieving | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Epilepsy/Seizure |
| <input type="checkbox"/> Injuries/ Surgeries | <input type="checkbox"/> Diabetes Type <u> </u> 1 <u> </u> 2 | <input type="checkbox"/> Other medical conditions we should be aware of? | |

If you checked any of the above, please briefly explain. We will discuss them before your massage.

No. of hours on computer /day _____

Activities that aggravate your pain: _____

Have you ever had cancer ? [YES] [NO] Type: _____

Date diagnosed: _____ Time Recovered: _____ WBC (4.5-10): _____ PLT (150-450): _____

Treatment/s: _____

Were any lymph nodes removed/irradiated? [YES] [NO] If yes, Neck [] Armpit [] Groin []