Client Health Form for Massage

Your Name_____ Date of Birth_____

Address_____

Telephone# (day) _____ (evening) _____ (cell) _____

Contact person_____ Relationship_____ PH#_____

Occupation_____ Physician _____

E-mail _____@_____

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Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage session? ☐ Yes ☐ No How Recently?_____

What are your massage goals? _____

What kind of pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

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If you answer yes to any of the following questions, please explain as clearly as possible.

☐Yes ☐ No	Do you smoke? ***How much?***	☐Yes ☐ No	Do you have any skin disorders? ***Where & what kind?***
☐Yes ☐ No	Do you have diabetes? ***What type?***	☐Yes ☐ No	Do you have any allergies? ***What kind?***
☐Yes ☐ No	Do you suffer from arthritis? ***Where?***	☐Yes ☐ No	Are you allergic to citrus, papaya or peanut? ***Other?***
☐Yes ☐ No	Do you have headaches? ***How often?***	☐Yes ☐ No	Allergic to any lotions/ointments?
☐Yes ☐ No	Do you have varicose veins? ***Where?***	☐Yes ☐ No	Do you have any heart conditions? ***Explain?***
☐Yes ☐ No	Do you have high blood pressure?	☐Yes ☐ No	Do you have any medical devises? ***What kind?***
☐Yes ☐ No	Have you had any surgery? ***Where?***	☐Yes ☐ No	Do you have osteoporosis?
☐Yes ☐ No	Do you or have you ever had cancer? ***Explain?***	☐Yes ☐ No	Do you suffer from back pain? ***Where?***
☐Yes ☐ No	Have you ever broken a bone? ***Where?***	☐Yes ☐ No	Do you have a sensitive area? ***Where?***

Notes_____

_____

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Current ***medications*** for other conditions or those mentioned above.

Name of medicine_____ to treat _____

Name of medicine_____ to treat _____

Name of medicine_____ to treat _____

Name of medicine_____ to treat _____

I have answered the above questions to the best of my knowledge, and will update any changed information each time I see my therapist.

Client Signature _____ Date _____

Therapist Signature _____ Date _____