



Therapeutic Massage - Client Information Form

Name _____ Address _____

primary phone # _____ Age: _____

secondary phone # _____ Would you like appointment reminders texted to you? Y or N

Referred by: _____

For what purpose are you seeking massage therapy?

General and Medical Information:

(This information is requested so your massage therapist can assess your current state of health as well as pinpoint if, how, and where your body experiences daily stress and / or injury.)

Are you currently under a doctor's care? Y or N If yes, for what condition(s)? _____

Do you take medications regularly? Y or N If yes, please indicate their purpose: _____

Is your range of motion limited in any way? If so, please describe: _____

Do you exercise regularly? Y or N If yes, indicate the number of hours and the type of exercise: _____

Do you have any hobbies that may compromise your posture or require repetitive movements of your hands, wrists, legs, arms? If so, please describe: _____

Have you had a professional massage before? Y or N How recent? _____



Please check the following items that DO APPLY to you. Your massage therapist may ask you to explain your answers in greater detail during the consultation to determine if there are any serious contraindications. Contraindications are conditions on specific areas of the body OR all encompassing conditions in which a massage would therefore be inadvisable.

- | | | |
|---|---|--|
| <input type="checkbox"/> arthritis | <input type="checkbox"/> pregnant | <input type="checkbox"/> high cholesterol |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> sinus draining now | <input type="checkbox"/> wearing contacts |
| <input type="checkbox"/> varicose veins | <input type="checkbox"/> high or low blood pressure | <input type="checkbox"/> wearing dentures |
| <input type="checkbox"/> frequent headaches | <input type="checkbox"/> taking b.p. medication | <input type="checkbox"/> skin sensitive/ irritated |
| <input type="checkbox"/> heart trouble | <input type="checkbox"/> major surgeries in last 2 yrs. | <input type="checkbox"/> joint swelling |
| <input type="checkbox"/> allergies | <input type="checkbox"/> currently injured | <input type="checkbox"/> cold, flu, or other contagion |
| <input type="checkbox"/> osteoporosis | <input type="checkbox"/> bruise easily | <input type="checkbox"/> hormonal disorder |
| <input type="checkbox"/> hepatitis | <input type="checkbox"/> cancer <input type="checkbox"/> in remission | <input type="checkbox"/> hysterectomy |
| <input type="checkbox"/> seizures | <input type="checkbox"/> panic attacks | <input type="checkbox"/> thyroid condition |

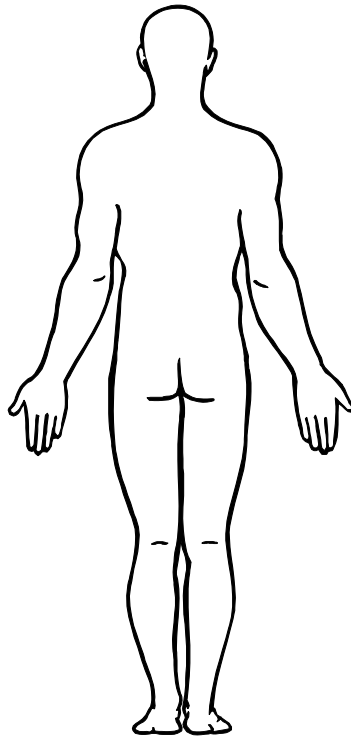
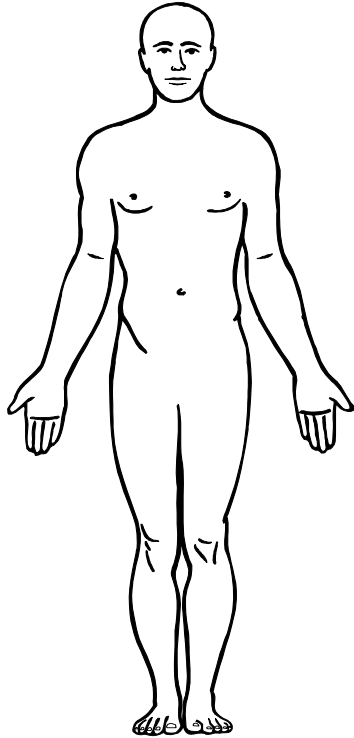
(a little more on back)

On the diagrams below:

Put an X on any painful area that should be avoided or dealt with very carefully.

Shade in any stiff areas.

Circle areas of other concern and describe the condition (for example, a scab, surgery scar, ticklish area, wart, ganglion, eczema, moles).



I have completed this information to the best of my knowledge. I understand the massage services are designed to be a health aid and are in no way to take the place of a doctor's care when it is indicated. Information exchanged during any massage session is educational in nature and is intended to help me become more familiar and conscious of my own health status, but is in no way to be construed as a medical diagnosis. I agree to keep the massage therapist updated as to any changes in my medical profile and understand there shall be no liability on the massage therapist's part should I fail to do so.

Client's who fail to notify the office of their inability to keep a scheduled appointment and simply do not show, will be charged 50% of their session price. I understand and also agree to the office no show policy terms.

Client Signature _____ Date _____