Massage Client Health History Form

Client Information and Release Form

Name _____ Birth Date _____

Address _____

City _____ State _____ Zip _____

Phone Number(s) _____ Home _____ Work _____ Cell

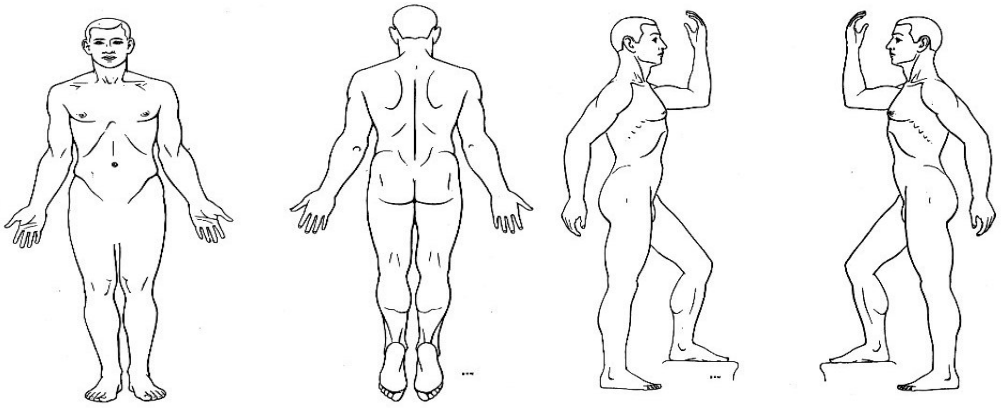
E-mail Address_____

Referred By _____Is this your first massage?_____

General Medical History

Check the box if you have or have had recent problems with any of the following:

☐ Arthritis	☐ High Blood Pressure	☐ Sinus / Allergies
☐ Bursitis	☐ Low Blood Pressure	☐ Hematomas
☐ Back Pain	☐ Poor Circulation	☐ Phlebitis
☐ Neck Pain	☐ Anemia	☐ Vericose Veins
☐ Arms / Hands (Pain)	☐ Stroke	☐ Cancer
☐ Hips / Legs / Feet (Pain)	☐ Chest Pain	☐ Skin Conditions
☐ Headaches	☐ Seizures / Convulsions	☐ Pregnant? ____# of months
☐ Swollen Joints	☐ Heart Conditions	☐ Menstrual Pain
☐ Fibromyalgia	☐ Constipation	☐ Warts
		☐ Athlete's Feet



Please circle any areas of pain, injury, tension, or restriction of movement.

Have you recently suffered an acute injury? _____

Have you had any recent surgery? _____

Do you have any other medical conditions that I should be aware of? _____

Where do you carry your stress and tension? _____

Do you wear contacts? _____

Do you have any problem areas / injuries? _____

Do you take any prescription medications? _____

Do you have any allergies? Yes or No, and if yes what are you allergic to? _____

Describe exercise activities that you do. Include Frequency. _____

Are you very sensitive to touch / pressure in any areas? _____

What type of pressure do you like? _____

What is your goal in the session today? _____

Please list any additional comments regarding your health and well being if needed. _____

_____

Your answers to these questions will be discussed with you prior to your session. Thank You.

Please take a moment to carefully read the following information and sign where indicated.

I understand that the massage I receive is provided for the basic purpose of relaxation, stress reduction, 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.

I further understand that massage should not be considered as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of.

I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnosis, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session(s) given should be considered as such.

Because massage 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 not be liability on the practitioner's part should I forget to do so.

Signature_____**Date** _____

Consent for minors is required prior to treatment.

Signature of Guardian_____ Date _____

Printed name of Guardian _____

Phone number the Guardian can be reached in case of emergency _____