CLIENT HISTORY

NAME	DATE

STREET	CITY	STATE	ZIP CODE

PHONE(S)

BIRTH DATE	REFERRED BY

PREVIOUS MASSAGE AND FREQUENCY

REASON FOR SEEKING MASSAGE

BENEFITS OR RESULTS YOU WOULD LIKE TO ACHIEVE FROM MASSAGE

CHECK ALL OF THE FOLLOWING CONDITIONS WHICH YOU ARE EXPERIENCING. THIS WILL HELP THE THERAPIST TO TAILOR THE MASSAGE TO MEET YOUR NEEDS.

- ☐ Allergies
- ☐ Arthritis
- ☐ Back Problems
- ☐ Blood Clots
- ☐ Bruising
- ☐ Cancer
- ☐ Cardiac or circulation problems
- ☐ Contagious disease
- ☐ Cramping
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fatigue
- ☐ Headaches
- ☐ Hearing aids
- ☐ Heart Condition
- ☐ High/Low Blood Pressure
- ☐ Infectious Condition
- ☐ Inflammation
- ☐ Insomnia
- ☐ Joint Problems
- ☐ Numbness or Stabbing Pain
- ☐ Osteoporosis
- ☐ Phlebitis
- ☐ Pregnancy
- ☐ Sciatica
- ☐ Sensitivity to touch or pressure
- ☐ Sinus Problems
- ☐ Skin Problems
- ☐ Stress
- ☐ Ticklishness
- ☐ Varicose Veins

Do you wear contacts? ☐Yes ☐No

Do you have problems with your dental work? ☐Yes ☐No

FURTHER EXPLANATION OR OTHER CONDITIONS

RECENT SURGERIES

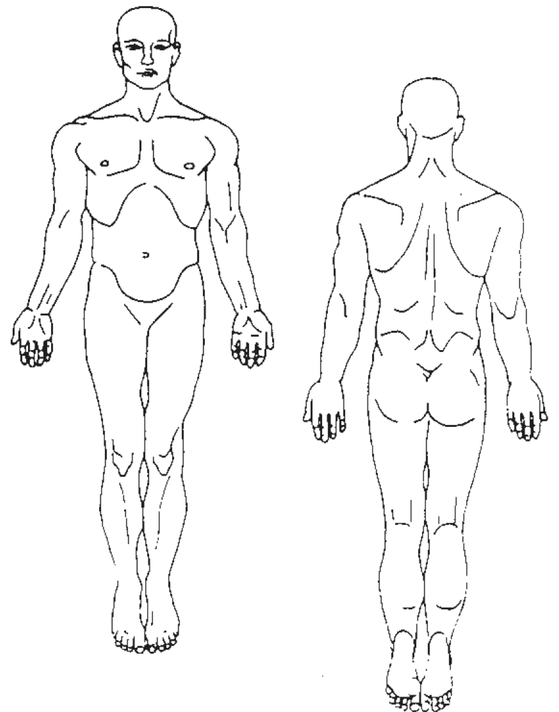
MEDICATIONS YOU ARE CURRENTLY TAKING

ACCIDENTS OR CURRENT INJURY, ILLNESS OR CONDITION REQUIRING SPECIAL ATTENTION OR CARE IN THE PAST 2 YEARS (BROKEN BONES, ETC.)

INDICATE WITH AN "X" YOUR PRESENT LEVELS OF:

HEALTH	LOW .... HIGH
ENERGY	LOW .... HIGH
STRESS	LOW .... HIGH

NOTE ANY ANATOMICAL AREAS OF TENSION, PAIN OR CHRONIC DISTRESS ON THE DIAGRAM AT RIGHT OR DESCRIBE:



SIGNATURE

Thank you for sharing this information. Everything in this questionnaire and all discussion during the massage is strictly confidential.