

**Client Health Information**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Male / Female: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Social Security # \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_

Referred by: \_\_\_\_\_

**Please list an emergency contact:** \_\_\_\_\_

Contact number: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Are you currently under the care of an MD , DC , PT , OT , other: \_\_\_\_\_

Referring Physician? \_\_\_\_\_ Physician's number: \_\_\_\_\_

Permission to consult with referring Physician? **Yes / No.** Please initial if yes: \_\_\_\_\_

Has there been a medical diagnosis? **Yes / No.** If yes, what was the diagnosis? \_\_\_\_\_

\_\_\_\_\_

Do you have any medical conditions, infectious or communicable diseases? **Yes / No.**

If yes, please describe: \_\_\_\_\_

Are you presently taking any prescription medication or supplements? **Yes / No.**

If yes, what type? \_\_\_\_\_

Please list (date and description) any significant accidents or surgeries: \_\_\_\_\_

\_\_\_\_\_

What is your major area of concern today? \_\_\_\_\_

When did this first occur? What brought it on? \_\_\_\_\_

What activities or movement aggravate the condition? \_\_\_\_\_

Is the condition getting worse? **Yes / No.** What makes it feel worse / better? \_\_\_\_\_

\_\_\_\_\_

When is it most uncomfortable? Morning , Afternoon , Evening , Night .

Does it interfere with work? **Y / N.** Sleep? **Y / N.** Daily activities? **Y / N.** Recreation? **Y / N.**

What have you done to get relief? \_\_\_\_\_

Please describe your exercise activities: \_\_\_\_\_

What are your expectations / goals for this visit? \_\_\_\_\_

## Client Health History

Please check the following conditions that apply to you, past and present. Please add your comments to clarify the condition if necessary.

Past/Present

**Musculoskeletal.**

- Joint stiffness / swelling
- Joint pain
- Broken / fractured bones
- Osteoporosis
- Osteoarthritis
- Herniated / bulging disk.
- Other: \_\_\_\_\_

Past/Present

- Spasms / cramps
- Strains / sprains
- Tendinitis
- Bursitis
- Rheumatoid Arthritis

Past/Present

- Headaches
- Jaw pain / TMJD
- Carpal Tunnel Syndrome
- Thoracic Outlet Syndrome
- Fibromyalgia

**Skin.**

- Eczema
- Psoriasis
- Herpes simplex
- Skin allergies
- Other: \_\_\_\_\_

- Warts
- Moles
- Acne
- Boils

- Ulcers
- Pressure sores
- Skin cancer
- Fungal infections

**Circulatory / Respiratory.**

- Heart attack
- Heart palpitations
- Stroke / TIA
- Blood clots / DVT
- Thrombophlebitis
- Varicose veins
- Anemia
- Other: \_\_\_\_\_

- High Blood Pressure
- Low Blood Pressure
- Hemophilia
- Raynaud's Syndrome

- Shortness of breath
- Dizziness / Fainting
- Asthma
- Sinusitis
- Tuberculosis
- Emphysema
- Allergies

**Digestive.**

- GERD (reflux)
- Irritable Bowel Syndrome
- Crohn's Disease
- Other: \_\_\_\_\_

- Indigestion
- Diarrhea
- Constipation

- Intestinal gas / bloating
- Hepatitis
- Cirrhosis

**Lymph / Immune / Endocrine.**

- Edema
- Lupus
- Chronic Fatigue Syndrome
- Other: \_\_\_\_\_

- Leukemia
- Lymphoma
- HIV / AIDS

- Diabetes
- Hypothyroid
- Hyperthyroid

**Nervous.**

- Parkinson's Disease
- Multiple Sclerosis
- Muscular Dystrophy
- Post / Polio Syndrome
- Other: \_\_\_\_\_

- Bell's Palsy
- Cerebral Palsy
- Numbness / tingling
- Neuritis

- Reduced sensation
- Seizure disorders
- Sleep disorders
- Depression

**Reproductive / Urinary.**

- Hysterectomy
- Pelvic Inflammatory Disease
- Bladder infection
- Other: \_\_\_\_\_

- Endometriosis
- Ovarian Cysts
- Pregnant

- Breast Cancer
- Prostate Cancer

**Other.**

- Drug use: \_\_\_\_\_
- Nicotine use: \_\_\_\_\_
- Alcohol use: \_\_\_\_\_
- Caffeine use: \_\_\_\_\_
- Hearing impaired: \_\_\_\_\_
- Visually impaired: \_\_\_\_\_

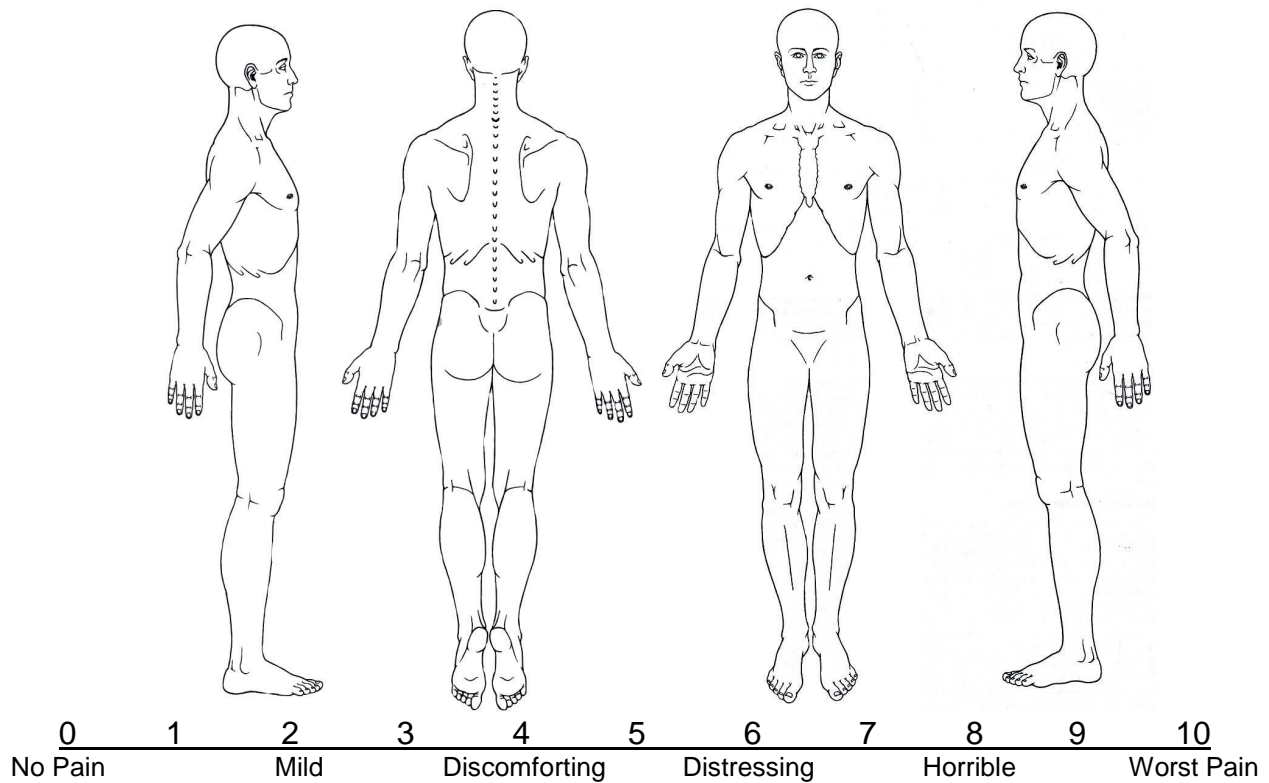
## Client Status Diagram

Please carefully shade on the body outline below, any areas that are currently causing you pain or discomfort, and rate the severity of the symptoms in those areas on a 0 - 10 pain scale.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Description:** (Circle or underline any of the adjectives below that apply to your discomfort)

Constant	Intermittent	Stiff	Tight
Dull	Sore	Aching	Heavy
Tender	Throbbing	Stabbing	Burning
Tingling	Other: _____		



### Consent for Care.

It is my choice to receive Massage Therapy. I am aware of the benefits and risks of Massage Therapy, and give my consent for care. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that Massage Therapy is not a substitute for medical examination and diagnosis, medical treatment or medications.

I have informed the Licensed Massage Practitioner (LMP) of all my known physical conditions, medical conditions and medications, and will inform the LMP of any changes in my health status. I understand that there shall be no liability on the LMPs part due to my forgetting to relay any pertinent information.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Session # \_\_\_\_\_ Time: \_\_\_\_\_