Massage Client History Form

General Information: **Please Circle All Applicable Items** **Referral:** Y ☐ N ☐

Name Last Can _____ First _____ Age ____ Date of Birth _____

Address _____ City _____ State _____

Zip _____ Ph (hm) _____ (wk) _____ Sex ☐ F ☐ M

Referred by _____ Sign Phone book Newspaper Website Other

Occupation _____ Employer _____ Email Address _____

Payment Information:

Will you be paying by: Cash ☐ Check ☐ Credit Card ☐ Auto Ins. ☐ Major Medical Ins. ☐ PPO / HMO ☐

*SS# csdfdfdfsdf453453 *Drivers Lic. # / Student ID _____ State _____

*(You must fill in Social Security and Drivers License numbers only if you are paying by insurance or personal check)

Current Concerns / Complaints:

1. _____ How Long? _____ Prior history? Y ☐ N ☐ Getting: Worse ☐ or Better ☐
2. _____ How Long? _____ Prior history? Y ☐ N ☐ Getting: Worse ☐ or Better ☐
3. _____ How Long? _____ Prior history? Y ☐ N ☐ Getting: Worse ☐ or Better ☐
4. _____ How Long? _____ Prior history? Y ☐ N ☐ Getting: Worse ☐ or Better ☐

Are your current complaints due to an injury? Y ☐ N ☐ Auto ☐ Work ☐ Sports ☐ Other _____

Has an accident been reported? Y ☐ N ☐ Have you retained an attorney? Y ☐ N ☐ Who? _____

Prior Treatment: OT ☐ PT ☐

Have you been treated for the above complaints by: Massage Therapist Chiropractor OSteopath M.D. Naturopath Acupuncturist Nutritionist Herbologist Other _____ Name of Provider _____

When? _____ Results of treatment _____

Do you have any history of massage care? Y ☐ N ☐ Please explain: _____

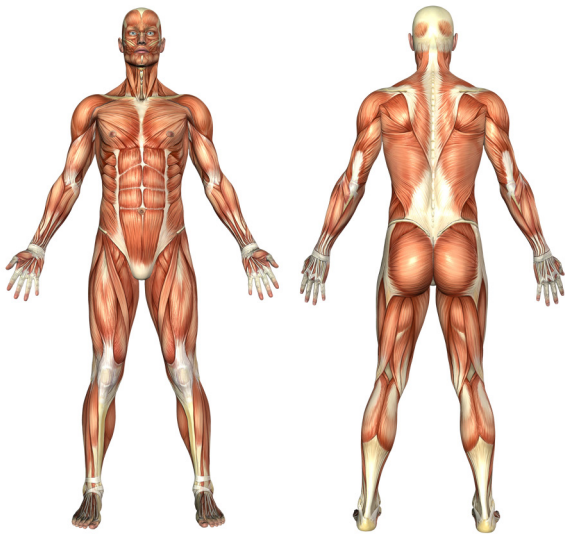
Patient: Please Complete

Please circle all areas and mark each one with:

P Pain
A Ache
S Stiff
N Numb
T Tingle
B Burn
C Spasm
W Weak

Please circle primary complaint severity

0 1 2 3 4 5 6 7 8 9 10



How Are Your Levels?

Water	High ☐	Med ☐	Low ☐
Sugar	High ☐	Med ☐	Low ☐
Sleep	High ☐	Med ☐	Low ☐

Therapists Assessment Notes Only

_____

_____

_____

_____

_____

_____

_____

Please complete the following before care is considered. Circle all applicable current items **-AND-** all recurrent items **-AND-** all previous diagnosis rendered from a health care provider.

Client Only	Therapist Only	Client Only	Therapist	ClientOnly	Therapist	Client Only	Therapist
Allergies		Shoulder pain		Asthma		Spitting blood	
Chills		Elbow/Wrist pain		Emphysema		Blood in urine	
Convulsions		Knee/foot pain		Deafness		Blood in stool	
Dizziness		Swollen joints		Ear noises		Freq. urination	
Fainting		Belching or gas		Thyroid disease		Diff. holding urine	
Fatigue		Indigestion		Hoarseness		Painful urination	
Headache		Acid Reflux		Bleeding		Prostate disease	
Loss of sleep		Irritable bowel		Easy bruising		Painful periods	
Weight gain		Diarrhea		Ear pain		Breast implants	
Nervousness		Excess hunger		Chest pain		Pregnancy	
Nerve pain		Jaundice		High blood press.		Seizures	
Night sweats		Hepatitis		Low blood press.		Depression	
Numbness		Liver disease		Heart pain		Anxiety	
Recur. twitches		Gall Blad. Disease		Heart disease		Cancer	
Tremors		Aids		Strokes		Diabetes	
Difficult breathing		Pancreatic disease		Ankle swelling		Contagious dis.	
Neck pain		Kidney disease		Feet swelling		Lupus	
Thoractic pain		Nausea		Varicose veins		Multiple Sclerosis	
Low back pain		Abdominal pain		Skin disease		Head Injury	
Hip pain		Loss of appetite		Arthritis		Spinal fractures	
Tail bone pain							

Additional Health Information

Surgeries ☐ **Initial here if you have never had any surgeries.**

List all surgeries	List all Dates	List all surgeries	List all Dates

Injuries: ☐ **Initial here if you have never had any injuries.**

List all significant accidents resulting in treatable injuries. Include auto and spinal injuries. List all Dates

List all medications and nutrition: ☐ Initial if you do not take medications, nutritional supplements, or herbs

Please list all diseases (diabetes, lupus, liver, kidney, cancer, etc.) for:

Yourself _____

Your immediate family _____

Do you: Smoke? ☐*Y* ☐*N* _____ *per day. Drink alcohol?* ☐*Y* ☐*N* _____ *per day. Exercise?* ☐*Y* ☐*N* _____ *x /wk*

Do you have any history of cancer? ☐*Y* ☐*N If yes, what type and when* _____

Have you recently been exposed to, or contracted any contagious diseases? ☐*Y* ☐*N* _____

By signing below, I agree that I have personally completed the above and that I have not omitted any relevant health history or information that may effect my care. I further consent to treatment understanding that there is inherent risk in all health care and that the risks are inherently low in the application of massage, and as such, I may occasionally experience stiffness, soreness, or
ache after a massage treatment.

Signature of patient or guardian _____ Date _____