

Client Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency Contact: _____ Phone: _____

Occupation: _____ Hobbies: _____

Health Insurance Plan: _____ ID# _____

Have you had a professional massage before?: Yes No

Are you currently seeing a medical professional?: Yes No

Are you currently taking any medication (including aspirin or ibuprofen)?: Yes No

Please list if yes: _____

Have you had any surgeries or injuries in the last 10 years?: Yes No

Please list if yes: _____

Do you have any allergies to any lotions, nuts, oils or food?: Yes No

Please list if yes: _____

What is your primary concern for today's session?: _____

What are your goals for today's session?: _____

What is your pain level today?: 1 2 3 4 5 6 7 8 9 10

Please check any that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart, Circulatory Problems | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Herpes | <input type="checkbox"/> Sleeping Disorders |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Spinal Column Problems |
| <input type="checkbox"/> Cancer, Tumors | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Sprains/Strains |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Implants (breast, calves, gluts) | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Muscle/Joint Pain | <input type="checkbox"/> Tendinitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> TMJ, Jaw Pain |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Rashes/Open Sores | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Respiratory Problems | |

I certify that the above information is true and accurate, if I am not eligible for health benefits through this provider I understand I am liable for all charges. I agree to notify my massage therapist if there is any change in my health condition or health plan provider. I understand that my therapist is not a Dr. and does not diagnose or treat any health conditions and is not a substitute for a professional health care provider. I acknowledge that my information is confidential and will not be released without my written consent.

Client Signature: _____ Therapist Signature: _____