CLIENT INFORMATION, HEALTH HISTORY, & CONSENT

(Please Print)

Legal Name: Last_____ First _____ MI _____

Hm Phone _____ Cell Phone _____ Wk Phone _____

Email _____ Date of Birth____/____/____ Sex: M F Gender_____

Address _____ City_____State_____Zip_____

Preferred method of contact (please circle) email Text Home phone Cell phone Work phone

Employer _____ Occupation_____

Work Activities (e.g. extended sitting, standing, walking, reaching, answering phones, etc.)_____

_____

_____

Emergency Contact _____ Relation to Client _____

Hm Phone _____ Cell Phone _____ Wk Phone _____

Massage / Bodywork History

Have you received massage / bodywork before: Yes_____ No____ How often? _____

What form(s) or style (s)? _____

_____

What depth of work have you received? *(Please Circle all that apply)* Light Medium Deep Very Deep

What depth of work do you prefer? *(Please Circle One)* Light Medium Deep Very Deep

What is your chief concern for massage today? _____

_____

Is there a secondary concern for today's session? _____

_____

Is there any region(s) of your body you do not want massaged? _____

Medical Care and Health Practices

Are you currently receiving care from a healthcare professional (MD / ND / Chiro / Other) ? Yes_____ No_____

If yes, please give their name and a brief explanation of the treatment. Name _____

Treatment: _____

_____

Are you currently using any prescriptions, supplements, herbs or other medications regularly? Yes___ No _____

If yes, please list and explain purpose of each _____

_____

_____

Please rate the frequency of your use/practice of the following as none, occasional, or regularly (light to heavy)

	NONE	OCCASIONAL	REGULAR	USE IS: LIGHT MODERATE HEAVY
Tobacco	____	____	____	L----------H
Sugar	____	____	____	L----------H
Alcohol	____	____	____	L----------H
Caffeine	____	____	____	L----------H
Marijuana	____	____	____	L----------H
Exercise	____	____	____	L----------H

Other Leisure and/or Recreational Activities? _____

_____

General Health: Please mark any condition that applies to you now or in the past.

Condition	LMT Comments

Use a **C for current, P for past.**

_____ Allergies *(specify)*
_____ Arthritis
_____ Asthma / Breathing Issue
_____ Blood clots
_____ Bruise easily
_____ Bursitis
_____ Cancer / Tumor
_____ Chronic pain condition
_____ Contagious Condition
_____ Depression / Anxiety
_____ Diabetes
_____ Dizzyness / Light-headed
_____ Fibromyalgia
_____ Headaches / Migraines

Condition	LMT Comments

Use a **C for current, P for past.**

_____ Heart Attack / Heart Disease
_____ High / Low Blood Pressure
_____ Insomnia / Sleep disturbance
_____ Joint Pain / Sprains
_____ Low Back Pain / Sciatica
_____ Lymphedema / Swelling
_____ Mental/Emotional Issues &/or Trauma
_____ Muscle Strain / Tension
_____ Neck / Cervical Pain
_____ Osteoporosis
_____ Pregnancy
_____ Skin Infections / Conditions
_____ Tendinitis / Tendinosis
_____ Varicose Veins / Phlebitis

Injuries, Surgeries, Major Illness

Injuries: Less than 5 years ago _____

_____

More than 5 years ago _____

_____

Surgeries: Less than 5 years ago _____

_____

More than 5 years ago _____

_____

Major Illness: Less than 5 years ago _____

_____

More than 5 years ago _____

_____

Other relevant health history? _____

_____

Overall Energy & Stress

Please rate/describe your energy level. I----------I
LOW AVERAGE HIGH

Please rate/describe your stress level. I----------I
LOW AVERAGE HIGH

What techniques/practices do you use to manage your stress? _____

_____

Please read and initial:

_____ All information given on the general information form & health history survey is complete & accurate. It is my responsibility to notify the student / LMT of any changes in my condition prior to treatment.
_____ I understand that my therapist does not diagnose illness or injuries, nor prescribe medical treatments.
_____ It is my choice to receive manual therapy and I give general consent to this session.

Signature _____ Date _____