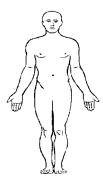
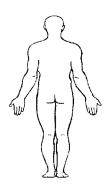
CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

First Name:	M.I		_ Last Name:_				
Address:		_ City:		_State:	Zip:		
Phone(h):	(w)			_Date of Birt	th:		
Employer:		_ Occupation	1:				
Emergency contact:	Phone:			_Relationship	p:		
Referred by:		_ e-mail:					
Is this your first professional massage?		_ If no, how	frequently do y	ou get a mass	age?		
What do you hope to accomplish from today's	massage?						
Are you aware of any tension holding spots in your body? If yes, location(s)							
Describe any surgeries, hospitalizations, accide	ents or injuries yo	ou have had:					
Less than 5 years ago:							
More than 5 years ago:							
What kind of care did you receive for your acc	eidents or injuries	?					
Do you feel that you have recovered from thes	e events?		Please exp	olain:			
Do you have any chronic, ongoing pain that yo	ou deal with on a	regular basis	?				
Please explain:							
Describe what activities cause this pain and/or							
Are you receiving any other type of medical tr							
Please list any medication (vitamins, herbs or p	pharmaceutical) t	aken now or	at regular inter	vals (include e	explanation of what		
medication is used to treat):							
Are you currently under the care of a physician	1?	Whom	?				
Please list reason(s):							
Are there any other health concerns you wish t							





Are you currently experiencing	g any of the followin	g conditions?		
Flu or Cold	Inflammation	Fever	Infection	Contagious Disease
Please check any of the follow	ing conditions below	that currently affect ye	ou or that you have	experienced in the last 5 years.
MUSCULOSKELETAL Fibromyalgia Spasms/Cramps Sprains/Strains Osteoporosis Postural Deviations Gout Osteoarthritis/Rheumatoid TMJ Cysts Bursitis Plantar Fascitis Tendonitis Torticollis Whiplash Syndrome Carpal Tunnel Syndrome Sciatica Thoracic Outlet Syndrome Headache Leg Pain Arm Pain/Shoulder Pain Low Back Pain Mid Back Pain Hip Pain Other RESPIRATORY Pneumonia Sinusitis Asthma Trouble Breathing	d Arthritis	CIRCULATORY Anemia Hemophilia Hypertension Low Blood Press Raynaud's Diseas Varicose Veins Heart Condition Blood Clots/Phle Diabetes Other DIGESTIVE Ulcers Irritable Bowel S Colitis Gallstones Hepatitis Crohn's Disease Diarrhea Gas/Bloating Indigestion Other SKIN Fungal Infections Acne Impetigo Dermatitis/Eczen Psoriasis Open Wound or S	ure se bitis yndrome	NERVOUS SYSTEM ALSMultiple SclerosisParkinson's DiseaseBell's PalsyNeuritisSpinal Cord InjuryStrokeTrigeminal NeuralgiaSeizure DisordersNumbness/Tingling/TwitchingOther OTHERInsomniaAnxiety/Panic AttacksPMSGrief ProcessCancerSubstance AbusePregnancyChronic FatigueHIV/AIDSHIV/AIDSHIV/AIDSHIV/AIDSBladder InfectionPostoperative SituationEdemaOther
Dizziness Other		Rashes Warts/Moles Athletes Foot Other		

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) may be charged in full for the price of the missed session.

Signature: