Massage Client information

Personal and confidential information.

Name_____ Birth Date_____

Address_____

City_____ Province_____ Postal Code_____

Phone, Hm_____ Cell_____ E-mail_____

Occupation_____

Emergency Contact_____ Phone_____

Doctor_____ Phone_____

Type of Massage: Relaxation Therapeutic Deep Tissue Pregnancy Post Partum

Therapist Communication Level: Minimal Moderate No Preference

General Information

What brings you in for a massage? _____

Have you had a massage before? Yes / No

Are you currently in any discomfort or pain? Yes / No If so where? _____

Have you seen your doctor for this problem? Yes / No

Were there any recommendations? _____

Do you suffer from dizziness, tension, irritability, or exhaustion? _____

Are you seeing any other healthcare providers? (i.e... Chiropractor, physiotherapy....) _____

_____

Medical Information

Please list any medication you are currently taking._____

_____

_____

Do you have any allergies? _____

Do you have pins, wires, artificial joints or limbs, spinal fusion, ruptured disc's, fused vertebrae, or special equipment? Yes/No If so please list._____

Have you taken in the last 4 hours... an analgesics, sedatives, or pain killers? Yes / No

Do you have any digestive disorders? Yes/No_____

Do you have.... Cancer. Yes / No Major illness. Yes / No Contagious disease. Yes / No

Have you had surgery in the last 12 months? Yes/ No

Please list any other issue that you may have and any active treatment for them!

_____

_____

MVA – Accident date/s_____

Any new diagnosis/medication in the past 12 months_____

_____

Do you have any of the following?

- HIV. Yes/ No
- Warts. Yes / No
- Acne, or open sores. Yes / No If so where_____
- Pitted Edema. Yes / No
- Diabetic. Yes / No Type 1/2
- Impetigo, Yes / No
- Whiplash. Yes / No _____
- Osteoporosis. Yes / No
- Planter fasciitis. Yes/ No
- Asthma Yes / No Is it well controlled Yes/ No
- Varicose veins, Yes/ No
- Blood disorders Yes/ No Type-_____
- Headaches, Yes/ No
- Kidney issues Yes/ No % of function -____
- Pregnancy , Yes/ No
- Epilepsy, Yes/ No
- Nerve disorders, Yes/ No
- Thyroid disorders Yes/ No / Removed
- Blood pressure problems. Normal / High / Low

Name of Client; _____

I understand that the massage I receive is provided for the basic purpose of relaxation, stress reduction, & relief of muscular tension. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician for diagnosis.

I understand that massage therapists are not qualified to perform skeletal adjustments, diagnoses and or prescribe, and that nothing said in the course of the session should be construed as such.

I have told the massage therapist all conditions here with in so that they can affirm that massage is good for me. I have answered all questions honestly and with full understanding that if not all information is given that injury may occur.

If 24 hour cancellation is not given for scheduled appointments,

I understand that I will be charged the full value of the massage, as per our office policy.

Signature_____

I also understand that any inappropriate comments made by myself,

(Client's name) _____ will result in immediate termination of the session, and will be liable for payment for the scheduled appointment.

Clients Signature _____ Date_____

Therapist Signature_____ Date _____