Confidential Client Information Form

Name ______________________________ Date ______________

Address ______________________________ Date of Birth __________

Telephone number - ______________ Email ____________________

HEALTH HISTORY

Reason for Visit: ________________

Is this your first professional massage? □**Yes** □**No**

Please state any recent injuries, accidents, medical treatment:

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Ailment	Past	Present	Ailment	Past	Present
Neck / Spine Injury	☐	☐	Liver Ailment	☐	☐
Back Pain	☐	☐	Kidney Ailment	☐	☐
Shoulder Pain	☐	☐	Diabetes	☐	☐
Sciatica/Leg Pain	☐	☐	Fibromyalgia	☐	☐
Heart Disease(s)	☐	☐	Cancer/Tumors	☐	☐
High Blood Pressure	☐	☐	Colitis	☐	☐
Low Blood Pressure	☐	☐	Ulcers	☐	☐
Headaches/Migraines	☐	☐	Infectious Disease	☐	☐
TMJ Syndrome	☐	☐	Epilepsy	☐	☐
Osteoarthritis	☐	☐	Asthma	☐	☐
Rheumatoid Arthritis	☐	☐	Mental Illness	☐	☐
Scoliosis	☐	☐	Grief Process	☐	☐
Skin Disorders	☐	☐			
Varicose Veins	☐	☐			

If you check any of the boxes above, please explain:

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Are you currently under the care of a physician? _____ Whom? ______________

Please list any/all medications, over the counter medicines, supplements / vitamins and/or herbs you are taking:

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Over please --- >

Please list any /all allergies or sensitivities you may have (foods, scents and lotions):
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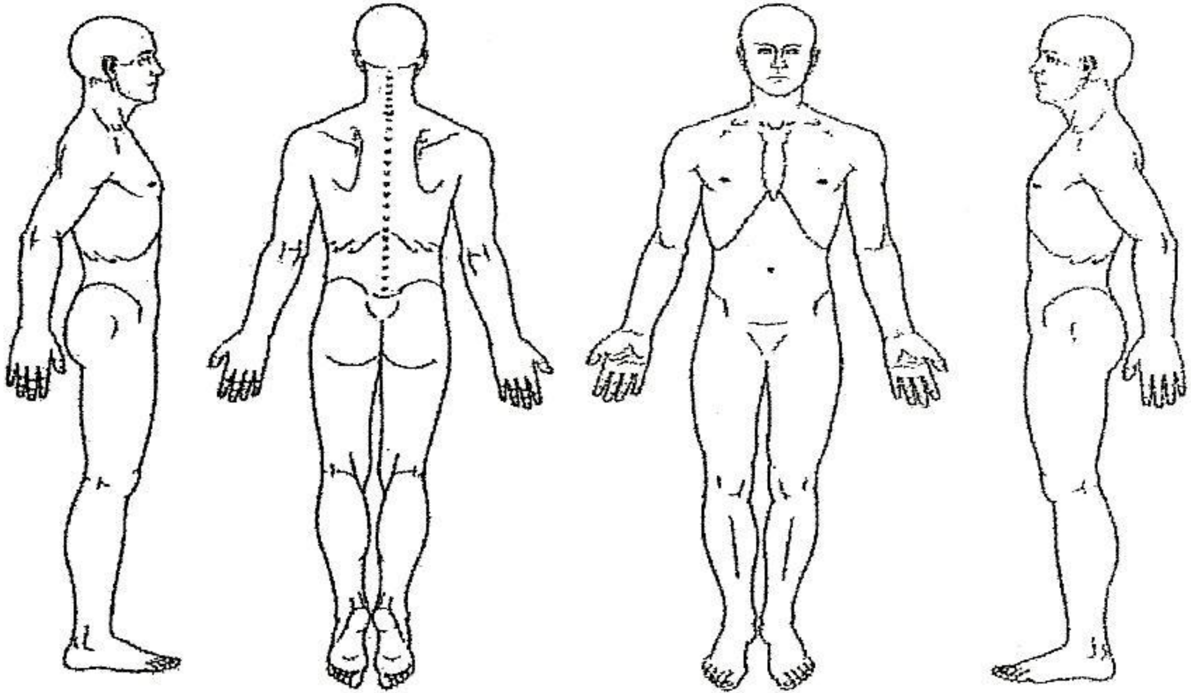
On the images below, please circle specific areas where you are **currently** experiencing pain, discomfort, lack of strength or mobility.



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Consent for care:

It is my choice to receive massage therapy, and I give consent to receive treatment. I understand that Massage Therapists DO NOT diagnose illness, disease or any other physical or mental disorders. Massage therapy is not a substitute for medical examination and/or diagnosis. I affirm that I have stated all my known medical conditions and shall take it upon myself to keep my Massage Therapist updated on my physical/mental health. I also agree there shall be no liability on the practitioner's part should I neglect to do so.

Signature:____Date ___________

Signature of parent/guardian:____________________________________Date ___________
(if patient is a minor)