Massage Therapy

Client Information
CONFIDENTIAL

Name: ______________________________________ **Date:** ____________________

Phone (H): (____)-______-_________ **Phone (W):** (____)-______-________

Email:____ **Date of Birth**________________**Age**_______

Address____________________________**City**_____________________**State**________ **Zip**________

Occupation______________________ **Referred By** ______________________

Primary Reason for Appointment:

____

____

Primary Physician: __________________________ **Telephone:** (____) _____ - _____

Recent Surgery: **Yes** **No** **If Yes, Please Describe:**

____

Do you have a condition that requires modification in the massage techniques: **Yes** **No**
If Yes, Please Describe:

____

____

Do you have any allergies (peanuts, latex, etc.):

____

Please check if you have any of the following:

☐ Allergies
☐ Arthritis
☐ Blood Clots
☐ Contact Lenses
☐ Dentures
☐ Diabetes

☐ Dizziness
☐ Headaches
☐ Heart Problems
☐High Blood Pressure
☐ Joint Disease
☐ Low Blood Pressure

☐ Open Lesions, Cuts
☐ Pregnancy
☐ Skin Problems
☐ Stress Issues
☐ Spinal Problems
☐ Varicose Veins

Please Describe:

____

____

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Please describe your current exercise program / activity levels:

____

____

Have you received massage before: Yes No

Illustrate area(s) of pain or unusual feeling. Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	● ● ● ● ● ●
Pins & Needles	○ ○ ○ ○ ○ ○
Burning	X X X X X X
Aching	* * * * * *
Stabbing	/ / / / / /

Please circle your level of pain or discomfort.

1 2 3 4 5 6 7 8 9 10

No pain Very Painful

Please identify any body areas you do NOT want addressed during the session:

____

____

Informed Consent

I, the undersigned, understand that massage therapy is for the purposes of stress reduction, relief from muscular tension, general relaxation, and improvement of circulation. I also understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorders; does not prescribe medical treatments or pharmaceuticals; nor does he/she perform any spinal manipulation.

I understand and acknowledge that professional massage therapy is not a substitute for medical treatment and that it is recommended that I see a physician for any physical ailment that I might have. I have indicated on this Massage Therapy Client Information Form all of my known medical conditions and take it upon myself to inform the massage therapist of any changes in my physical health. With this in mind, I agree that the massage therapist cannot be held liable for any problems that might arise as a result of my massage sessions.

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Participant's Signature (Signature of parent or legal guardian if participant is under the age of 18)

____

Date

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Client ______________________________________ Page _________

Date	Treatment Notes

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