Client History Form

Personal Information

Name_____ Date of Birth_____

Address_____City,state,zip_____

Home phone_____ Cell phone_____ Email_____

Occupation_____ Referred By_____

Emergency contact name_____ Emergency contact phone_____

Physician's name_____ Physician's phone_____

Massage Experience

Have you had a professional massage before? Yes No If yes, What type of massage(s)_____

What pressure do you prefer? Light Medium Deep _ Do you have any allergies or skin sensitivity?_____

Are there any areas that you do not want massaged (face, feet, abdomen, etc.)_____

Have you recently had any injury, surgery, or areas of inflammation? Yes No

If yes, describe_____

List any prescribed and over the counter medications that you are currently taking_____
_____

PLEASE CIRCLE BELOW ALL THAT APPLY TO YOUR HEALTH HISTORY

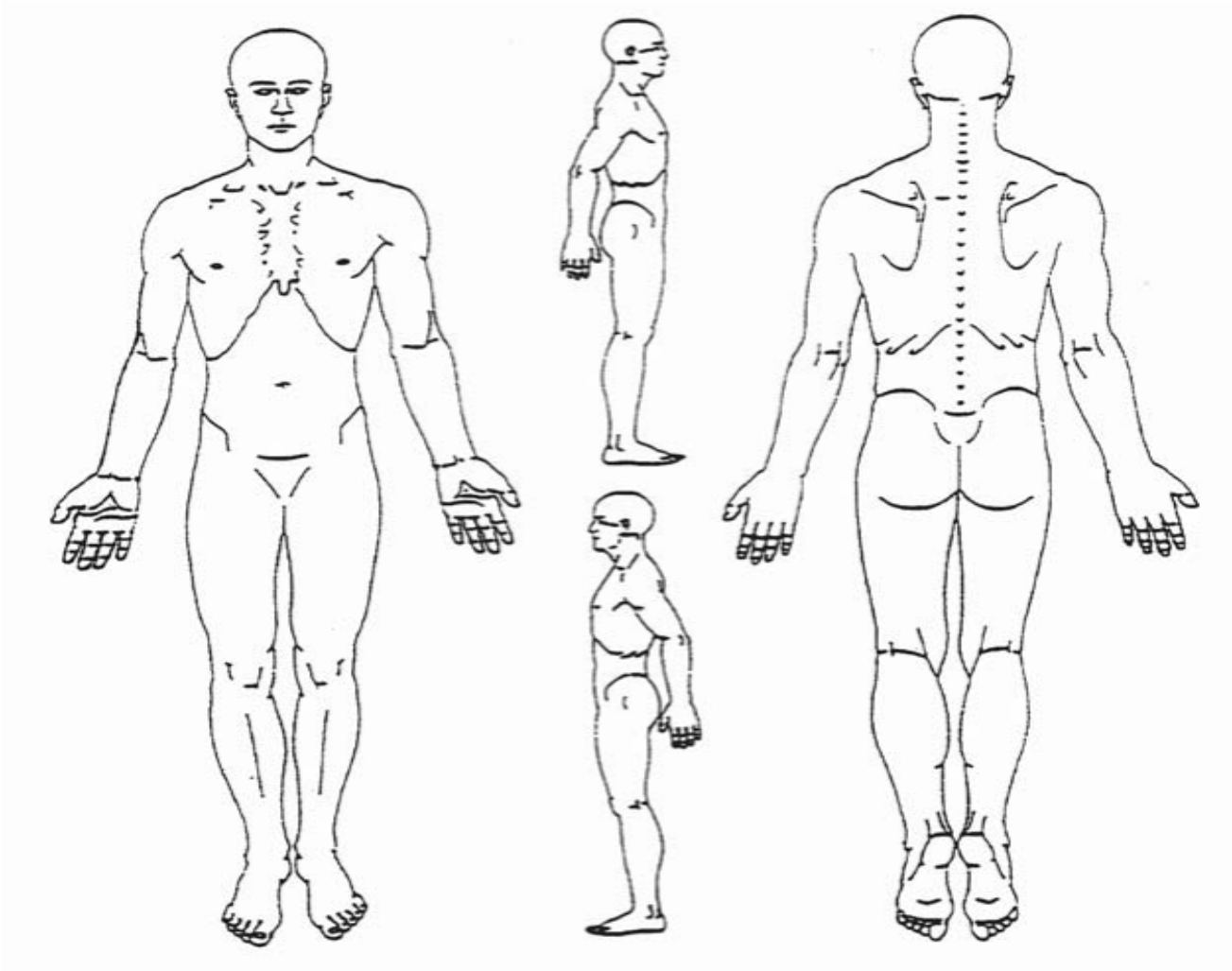
Musculoskeletal	**CardioVascular**	**Skin & Infections**	**Psychological**
Tendonitis/Bursitis Arthritis/Osteoporosis Jaw Pain (TMJ) Lupus/Fibromyalgia Spinal Problems Migraines/Headaches Pins/plates/wires/artificial joints **Nervous System** Numbness/Tingling Pinched Nerve/Sciatica Paralysis/Epilepsy Multiple Sclerosis/ Parkinson's Disease Chronic Pain, where?_____ _____	Heart Attack/Heart Disease Phlebitis/Varicose Veins Blood Clots/Stroke/Pacemaker High or Low Blood Pressure Lymphedema/ Poor circulation Congestive Heart Failure Hemopheliia **Digestive** Irritable Bowel Syndrome Bladder/Kidney Ailment Colitis/Crohn's Disease/Ulcers **Respiratory** Shortness of Breath/Asthma Emphysema/chronic cough Sinusitis Smoker	Hepatitis/HIV/AIDS Rashes/Herpes/Cold sores Tuberculosis/Lyme disease Athlete's Foot/Infectious skin disorder/Skin Cancer Allergies, specify: _____ **Reproductive** Pregnant, stage _____ Gynecological problems Given birth recently, when?_____ **Other** Cancer/Diabetes type 1 or type 2 Chronic fatigue syndrome Contact Lenses Dentures/Hearing Aids	Anxiety/Depression/Stress Any other medical condition(s) not listed:_____ _____ _____ _____ Please explain any of the conditions that you have marked above:_____ _____ _____ _____

By signing below, I agree that the I completed this form to the best of my knowledge and agree to inform my therapist of any changes to my health status. I also agree that it is my choice to receive massage therapy, I am aware of the benefits and risks of massage and give my consent for massage. I understand that massage therapy is not a substitute to medical care, medical examination or diagnosis.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment. I understand that Therapeutic Body Works does not file insurance and that payment is due at time of service.

Signature_____ Date_____

(Complete diagram on next page)



PLEASE CIRCLE AREAS ABOVE THAT AREA CAUSING DISCOMFORT