

# massage therapy confidential client record/health screen

## CONTACT INFO:

Date: \_\_\_\_\_

Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Ph: \_\_\_\_\_ Evening Ph: \_\_\_\_\_

## LIFE SNAPSHOT:

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Personal Fitness/Wellness Goals: \_\_\_\_\_

\_\_\_\_\_

Describe your workout: (include frequency) \_\_\_\_\_

\_\_\_\_\_

Have you ever had a professional massage or other bodywork? Yes \_\_\_ No \_\_\_

If yes, please describe: \_\_\_\_\_

Do you use: Tobacco? \_\_\_ Alcohol? \_\_\_ Caffeine? \_\_\_

Any nutritional/eating concerns? \_\_\_\_\_

On a scale of 1 to 10 (highest), what is your stress level? \_\_\_ Pain level? \_\_\_

Is there any area of your body where you seem to hold a lot of tension or experience chronic pain? \_\_\_\_\_

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## MEDICAL RECORDS:

Are you currently under medical/therapeutic treatment? \_\_\_ If yes, for what condition(s)? \_\_\_\_\_

\_\_\_\_\_

Please list your care provider's name and phone number: \_\_\_\_\_

\_\_\_\_\_

List any medications (including aspirin or birth control) and nutritional supplements you are taking: \_\_\_\_\_

\_\_\_\_\_

Please list (date and descriptions) any accidents or operations you have had:

\_\_\_\_\_

\_\_\_\_\_

I have stated all conditions I am aware of and this information is true and accurate. I will inform the massage therapist of any changes in my status. Also, I am aware that therapeutic massage is meant to enhance my health and overall well-being and not to bring about instantaneous healing. In signing this, I also am agreeing that if I am unable to cancel an appointment 24 hours in advance that I will be billed for said session to be left up to the therapist's discretion.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

## client status

Name: \_\_\_\_\_ Date: \_\_\_\_\_