Welcome! Please complete this information to help the therapist get to know you and so your therapy can be customized to your needs. This information is confidential and will only be used in the development of your massage therapy treatment plan. If an outside party requests this information, it will be released only after written permission is obtained from you, the client, or through a court order.

**General Information**

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

Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Province\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical / Health History**

*Please mark an* ***(X)*** *by all current conditions and* ***(P)*** *for all past conditions:*

|  |  |  |
| --- | --- | --- |
| \_\_ Abdominal/Digestive Problems  \_\_ Allergies- If yes please specify:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_ Aneurysm  \_\_ Anxiety  \_\_ Arm/Hand Pain  \_\_ Arthritis/tendonitis  \_\_ Artificial Joint  \_\_ Atherosclerosis  \_\_ Asthma or lung condition  \_\_ Athletes foot/Warts  \_\_ Back or Neck Problems  \_\_ Bladder or Kidney Ailment  \_\_ Blood Clots  \_\_ Blood Pressure: ᴏ Low ᴏ High  \_\_ Bone or Joint Disease  \_\_ Bruise Easily  \_\_ Cancer  \_\_ Carpal Tunnel Syndrome  \_\_ Chemical Dependency (Alcohol, Drug)  \_\_ Chronic Fatigue  \_\_ Chronic Pain  \_\_ Circulatory/Heart Problems  \_\_ Constipation/ Diarrhea | \_\_ Contagious Skin Condition  \_\_ Current Fever  \_\_ Decrease Sensation  \_\_ Depression  \_\_ Diabetes  \_\_ Diverticulitis  \_\_ Eating Disorders  \_\_ Epilepsy  \_\_ Fibromyalgia  \_\_ Headaches, Migraine  \_\_ Hearing Problems  \_\_ Heart Attack  \_\_ Heart Condition  \_\_ Hepatitis (A, B, C, other)  \_\_ Hernia  \_\_ Herpes/cold sores  \_\_ HIV/AIDS  \_\_ Irritable Bowel Syndrome  \_\_ Liver Disease  \_\_ Lupus  \_\_ Lymphedema  \_\_ Jaw Pain/ TMJ pain  \_\_ Joint Dislocations  \_\_ Mental/Psychological Condition  \_\_ Muscle/Bone Injuries  \_\_ Muscle/Joint Pain | \_\_ Muscle Spasms or Cramping  \_\_ Numbness/Tingling  \_\_ Open Sores or Wounds  \_\_ Ovarian/Menstrual Problems  \_\_ Osteoporosis  \_\_ Pinched Nerve  \_\_ Pregnancy  \_\_ Rash/fungus  \_\_ Scoliosis  \_\_ Seizures  \_\_ Shingles  \_\_ Sinus Problems  \_\_ Sleep Difficulties/Disorders  \_\_ Spinal Disorders  \_\_ Sprain/Strain  \_\_ Stroke  \_\_ Swollen Glands  \_\_ Tennis Elbow  \_\_ Tension/Stress  \_\_ Thyroid Problems  \_\_ Ulcers  \_\_ Undiagnosed Acute Pain  \_\_ Vision Problems  \_\_ Varicose Veins  \_\_ Whiplash  \_\_ Other (describe below) |

Are there any other medical conditions that you have which are not listed above that we should know about?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Injuries, accidents or illnesses that are still affecting you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear contact lenses or glasses: ᴏ Yes ᴏ No Recent Surgery? ᴏ Yes ᴏ No

How would you rate your state of health? ᴏ Excellent ᴏ Good ᴏ Fair ᴏ Poor

Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Family Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any current medications you are taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following today: ᴏ Skin Rash ᴏ Cold/Flu ᴏ Open Cuts ᴏ Severe Pain ᴏ Anything Contagious

ᴏ Bruises/Injuries

Do you have any allergies to oils, lotions, or ointments? ᴏ Yes ᴏ No If yes please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

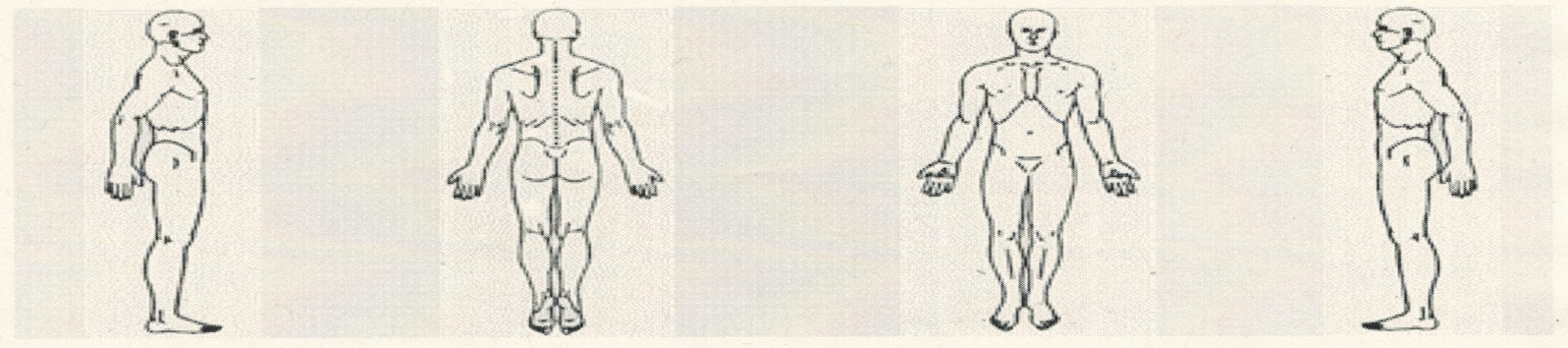
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Massage Session Information**

Please indicate with an (X), if any, the areas in which you are currently feeling discomfort. Please indicate with an (M), if any, the areas which you would like your therapist to focus on today.



What results are your goals/expectations for this massage therapy session? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any concerns about getting a massage today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to: need to move or change position, sighing, yawning, change in breathing, stomach gurgling, emotional feelings and/or expression, movement of intestinal gas, energy shifts, falling asleep, memories.

**Consent**

Please read the following information and sign below:

1. I understand that the therapist has informed me of their credentials, and has informed me of treatment costs, and my financial obligations.
2. I understand that it is my choice to receive massage therapy, and receive it at my own risk.
3. I understand that massage therapy is beneficial for relaxation, relief from pain, tension, and stress and increase in circulation.
4. I understand that massage therapists do not preform medical examination, diagnose illness, disease or mental disorders; nor do they prescribe any medical treatment, pharmaceuticals, or perform any spinal manipulation, and that it is recommended that I see my physician for any ailment that I may have.
5. I understand that I am responsible to inform my therapist at each visit of any changes to my health.
6. I have truthfully stated all medical and health conditions that I am aware of, and this information is accurate to the best of my knowledge.
7. I understand that not informing the therapist of critical health information could result in injury due to contraindications for massage. I understand that massage is contraindicated for some medical conditions and that obtaining a medical clearance or prescription may be necessary before beginning treatment.
8. I understand that draping will be used during the session and that only the area being worked on will be uncovered.
9. I will, if I experience any pain or discomfort during the massage, immediately inform my massage therapist so that the pressure and/or methods can be adjusted to my comfort level.
10. I understand that this is a therapeutic massage, and that any sexual advances, request for sexual favors, or other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will terminate the session, and that I will be liable for full payment of the scheduled treatment.
11. I understand that this form, and any treatment notes prepared by the therapist regarding treatment that I receive may be shared with other therapists and health practitioners within this clinic, and by signing below I provide permission to do so.
12. I understand that if the massage therapist starts a session late, they will make it up to me at the end of my session, if possible, or will reduce my fee accordingly. I understand that if I arrive late, my session will end at the originally scheduled time so the client following me is not penalized.
13. I agree to give 24 hour notice for a scheduled session that I cannot keep. I am aware that I may be charged the full fee for any missed sessions or for sessions that I do not give 24 hour notice to cancel or reschedule.
14. In the event that I become injured, either directly or indirectly, as a result, in whole or in part, of the aforesaid massage therapy, I hereby hold harmless and indemnify the therapist, their principals, and agents from all claims and liability whatsoever.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to minor being treated (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_