



Massage Therapy History

Case # _____ Date _____

We would like to make your massage therapy session as pleasant and comfortable as possible. Please be sure to arrive a few minutes early so you don't feel rushed. Scheduled massage times include time for disrobing (to your comfort level) and dressing after the massage. The following information will be helpful plan a safe and effective massage session.

Client Information

Full Name _____ Nickname _____

Address _____ City _____ State _____ Zip _____

Sex: () M () F Age: _____ Birth date: ____/____/____ E-mail address: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Occupation/Employer: _____

How did you hear about our clinic? _____

Are you currently under chiropractic care? No Yes If yes, are you a patient of Life Refined? Yes No

Emergency contact name: _____ Phone: (____) _____

Massage Information & Health Questions

Everyone reacts differently to massage therapy. During your massage, it is normal to feel the need to move or change position, sigh, yawn, or have a change in breathing pattern, experience stomach gurgling or the movement of intestinal gas, experience emotional feelings (crying), or fall asleep. After your massage, it is not unusual to experience muscle soreness from the toxins released during your session. It is extremely important to hydrate with water before and after your massage to help reduce this effect.

What is the purpose for you seeking massage therapy today? _____

Have you ever had a professional massage before? Yes No

If yes, how often do you receive massage therapy? _____

If yes, when was your last massage? _____

If yes, what kind of massage? Swedish Deep Tissue Sports Pregnancy Other: _____

Do you have any allergies to oils, lotions or ointments? Yes No

If yes, please explain: _____

Do you have sensitive skin? Yes No

If yes, please explain: _____

Are you wearing: Contact Lenses? Yes No Dentures? Yes No Hearing Aid? Yes No

Do you have any difficulty lying on your front, back or side? Yes No

If yes, please explain: _____

Do you sit for long hours at a workstation, computer or driving? Yes No

If yes, please describe: _____

Do you perform any repetitive movement in your work, sports or hobby? Yes No

If yes, please describe: _____

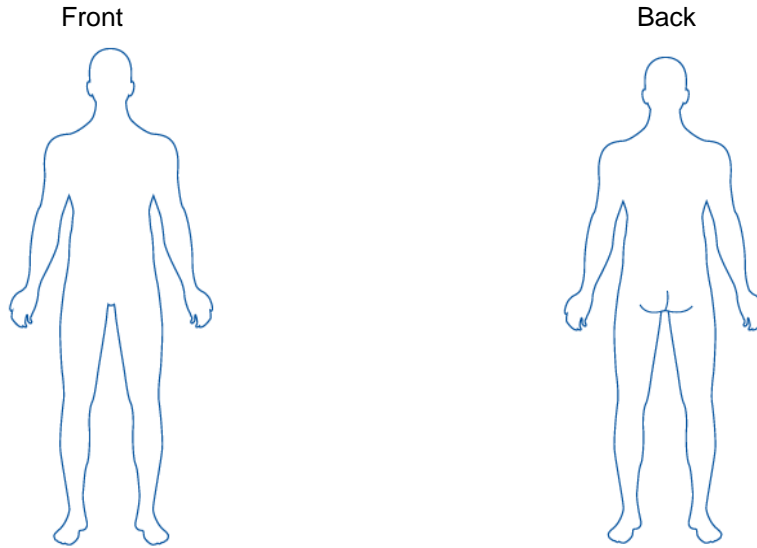
Do you experience stress in your work, family, or other aspect of your life? Yes No

If yes, how do you think this stress is affecting your health? Mild Moderate Severe

Is stress affecting any of the following? Muscle Tension Anxiety Insomnia Other: _____

Are there any particular areas of the body where you would like your massage therapist to concentrate? Yes No

If yes, please mark the areas on the diagrams below.



Health History Overview

Are you currently taking any prescription medications? Yes No

If yes, please list the name and reason for medications: _____

Are you currently under the care of a medical professional for any conditions?

- | | |
|---|--|
| <input type="checkbox"/> contagious skin condition | <input type="checkbox"/> phlebitis |
| <input type="checkbox"/> open sores or wounds | <input type="checkbox"/> deep vein thrombosis / blood clots / varicose veins |
| <input type="checkbox"/> easy bruising | <input type="checkbox"/> joint disorder / rheumatoid arthritis / osteoarthritis / tendonitis |
| <input type="checkbox"/> recent accident or injury | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> recent fracture | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> recent surgery | <input type="checkbox"/> headaches/migraines |
| <input type="checkbox"/> artificial joint | <input type="checkbox"/> cancer |
| <input type="checkbox"/> sprains / strains | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> current fever | <input type="checkbox"/> decreased sensation |
| <input type="checkbox"/> swollen glands | <input type="checkbox"/> back / neck problems |
| <input type="checkbox"/> allergies / sensitivity | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> heart condition | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> high or low blood pressure | <input type="checkbox"/> carpal tunnel syndrome |
| <input type="checkbox"/> circulatory disorder | <input type="checkbox"/> blood disorders (hemophilia, clotting disorder, etc.) |
| <input type="checkbox"/> atherosclerosis | <input type="checkbox"/> pregnancy If yes, estimated due date? _____ |

Consent for Care

I, the undersigned, understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for care from a primary healthcare practitioner. I understand that massage should not be performed under certain medical conditions, and I affirm that I have answered all questions about my health and any medical conditions truthfully. I also understand that payment is due at the time of service, that I am responsible for payment of any missed appointments and arriving late for scheduled appointments will incur the full fee, with the massage session lasting for the remaining time of the scheduled session.

Signature: _____ Date: _____