

Clinical Therapeutic Massage Client Health Information Sheet

Clients Name: _____ Date: _____

Address: _____ City _____ Zip _____

Day Time Phone: _____ Evening Phone: _____ Email _____

Date of Birth: ____ / ____ / ____ Occupation: _____

Marital status: Single Married Name of Spouse/Significant Other: _____

Children's Names and Ages: _____

Referred by: _____

Emergency Contact _____ Phone: _____

Present Symptoms: What is your major complaint or condition you want to improve? _____

When did you first notice major complaint _____

What brought it on? _____

What activities aggravate the condition? _____

Is this condition getting progressively worse? Yes No
Please Explain: _____

Does this condition interfere with work? Sleep? Daily Routine?
Please Explain: _____

What have you done to get relief? _____

Has there been a medical diagnosis? Yes No
If yes, by whom? _____

Please Explain: _____

Have you had X-rays taken? Yes No

If yes, by whom? _____

What are your expectations for this visit? _____

Are you now under medical/therapeutic treatment? Yes No

If yes, for what condition? _____

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

List any medications (including aspirin) and nutritional supplements you are taking: _____

Describe the exercise activities you do (include frequency): _____

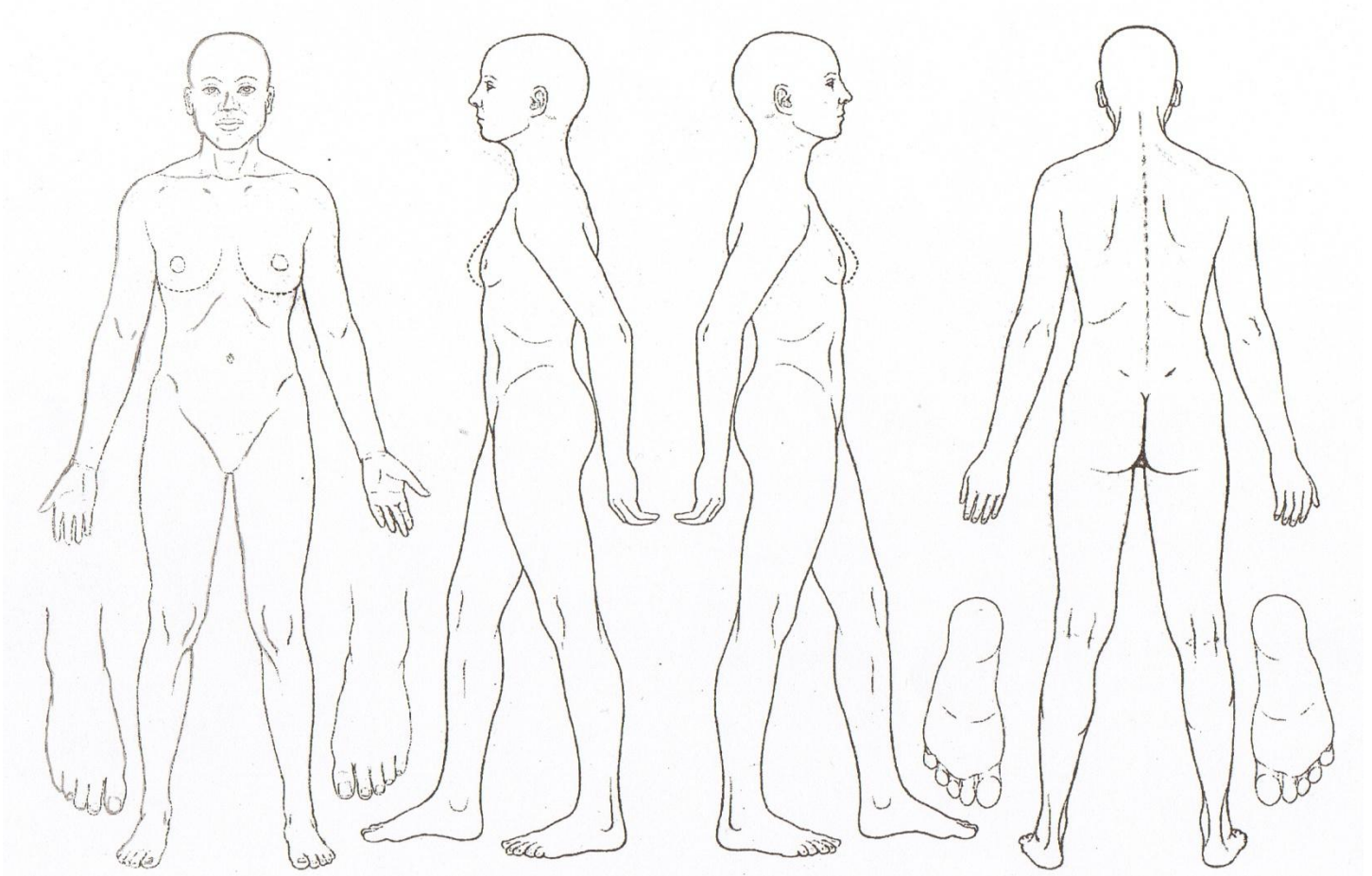
List other therapies you receive: _____

Please list (date and description) any accidents or operations: _____

Please list any additional comments regarding your health and well-being _____

Because a massage therapist must be aware of any existing physical conditions, I have listed all my known medical conditions and physical limitations and will inform the massage therapist in writing of any change in my health. I understand massage therapists do not diagnoses illness, disease, or any other medical, physical, or emotional disorder; nor do they perform any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailment that I have. Unless arrangements are made beforehand, payment is due at the time of appointment. The hourly rate is \$80. I also understand that if I need to cancel or reschedule my appointment I must give a 24 hour notice or \$75 cancellation fee, for missed appointments not canceled within 24 hours, may be applied.

Clients Signature _____ **Date** _____



Circle the locations of symptoms, labeling pain, stiffness/tightness, scars, swelling, spasms, etc.
Also label injuries (previous or present):