CLEVELAND
MOBILE MASSAGE

Client Information

Name: _____ Date:_____

Address: _____ City: _____

State: _____ Zip: _____ D.O.B._____ Sex: _____Male _____Female

Phone #_____ E-mail_____

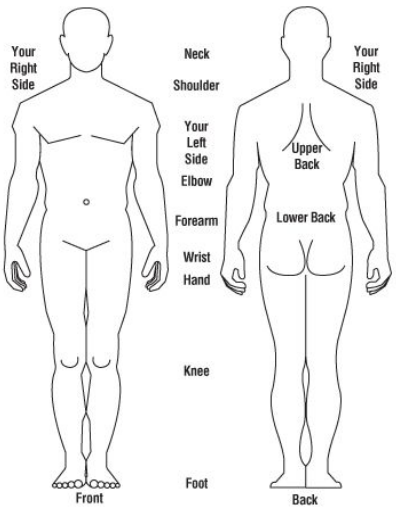
Referred by: _____ Occupation: _____

Have you ever received massage therapy? Yes_____ No_____

Frequency of treatments: _____Weekly _____Monthly

Type of pressure preferred (Circle): Firm Medium Light

Current Chronic Pain/Areas of Concern (Please Mark Area on Diagram Below):



How long have you had the present condition(s)?

_____

Are you currently under a Physician's care?
Yes_____ No_____

If Yes, please list name and phone number of Physician:

_____

_____

List all medications you are currently taking and purpose:

_____

_____

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MUSCULOSKELETAL

- ❑ Bone/Joint disease_____
- ❑ Tendonitis/Bursitis_____
- ❑ Arthritis/Gout_____
- ❑ Jaw pain (TMJ)_____
- ❑ Lupus_____
- ❑ Spinal problems_____
- ❑ Baker's Cyst_____
- ❑ Bunion_____
- ❑ Osteoporosis_____
- ❑ Other_____

CIRCULATORY

Heart Complications_____
Phlebitis/Varicose veins_____
Blood clots_____
High/Low Blood pressure_____
Lymph Edema_____
Thrombosis/Embolism_____
Anemia _____
Other_____

RESPIRATORY

- ❑ Breathing difficulty_____
- ❑ Emphysema_____
- ❑ Allergies Specify:_____
- ❑ Sinus problems_____
- ❑ Asthma_____
- ❑ COPD_____
- ❑ Other_____

SKIN

Allergies specify: _____
Psoriasis_____
Eczema_____
Herpes/cold sores_____
Warts_____
Other_____

NERVOUS

- ❑ Shingles_____
- ❑ Numbness/Tingling_____
- ❑ Pinched Nerve_____
- ❑ Seizures_____
- ❑ Sciatica_____
- ❑ Parkinson Disease_____
- ❑ Other_____

DIGESTIVE

Irritable Bowel Syndrome_____
Constipation_____
Diarrhea_____
Reflux Disease_____
Hepatitis_____
Other_____

REPRODUCTIVE

- ❑ Pregnant/Trimester_____
- ❑ Menstruation_____
- ❑ Prostate_____
- ❑ Other_____

OTHER

Cancer/Tumors_____
Sleep Apnea_____
Diabetes_____
Drug/Alcohol Use_____
Injuries/Surgeries_____
Anxiety Disorder_____
Migraines/Headaches_____

Additional client remarks:
_____
_____