Divine Reiki and Massage

Massage Client Information Form

Contact Information:

Client Name (Please Print) _____
Date _____
Date of Birth _____
Primary Phone _____ Circle one: cell home
Alternate Phone _____ Circle one: cell home work
Address _____
City State Zip _____
Email _____
How did you hear about me? _____
I consent to receive appointment reminders via email/text □ Yes □ No
Emergency contact _____
Physician name _____
Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes □ No □
Do you have a physician referral/prescription? □ Yes □ No
Are you wearing contacts? □ Yes □ No
Are you wearing dentures? □ Yes □ No
Are you wearing a hairpiece? □ Yes □ No
Are you pregnant? □ Yes □ No

Massage Information:
Have you ever received professional massage/bodywork before? □ Yes □ No
What kind of pressure do you prefer? □ Light □ Medium □ Hard
What are your goals/expected outcomes for receiving massage/bodywork?
_____
_____
How do you feel today?_____
List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.): _____
_____
Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? □ Yes □ No
Explain:_____
_____
List the medications you currently take:
_____

Health History:

Have you had any injuries or surgeries in the past that may influence today's treatment? _____

Circle any of the following health conditions that you currently have (If you are unsure, please ask):
blood clots, infections, congestive heart failure, contagious diseases, pitted edema
*Please answer honestly, as massage may not be indicated for the above conditions

Please indicate conditions that you have or have had in the past. Explain in comments details including treatment received:

Muscle or joint pain	Current Past
Muscle or joint stiffness	Current Past
Numbness or tingling	Current Past
Swelling	Current Past
Bruise easily	Current Past
Sensitive to touch/pressure	Current Past
High/Low blood pressure	Current Past
Stroke, heart attack	Current Past
Varicose veins	Current Past
Shortness of breath, asthma	Current Past
Cancer	Current Past
Neurological (e.g. MS, Parkinson's, chronic pain) Epilepsy, seizures	Current Past
Headaches, Migraines	Current Past
Dizziness, ringing in the ears	Current Past
Digestive conditions (e.g. Crohn's, IBS)	Current Past
Gas, bloating, constipation	Current Past
Kidney disease, infection	Current Past
Arthritis (rheumatoid, osteoarthritis)	Current Past
Osteoporosis, degenerative spine/disk	Current Past
Scoliosis	Current Past
Broken bones	Current Past
Allergies	Current Past
Diabetes	Current Past
Endocrine/thyroid conditions	Current Past
Depression, anxiety	Current Past
Memory Loss, confusion, easily overwhelmed	Current Past

Comments _____
_____
_____