Client History Information 1

Name:_____ **Birthdate:**_____/_____/_____

Address:_____

City/St/Zip:_____

Primary Phone:_____
Secondary#:_____

Email:_____
Secondary EM:_____

Occupation:_____
Employer:_____

Emergency Contact:_____
Phone #:_____

Reason for today's visit?

_____

_____

Have you ever had a professional massage treatment before? Yes____ No____

Are You: Pregnant_____ Trying _____ Miscarriage(s)_____ Menstruating **Y / No**

Please mark if you have or had any of the following conditions:

____Heart conditions
____Skin Disorders
____Diabetes
____Arthritis
____Broken Bones
____Sciatic Pain
____Neuropathies
____Breast Augmentation
____Degenerative Diseases
____High Blood Pressure (HBP)
____Cancer
____Immune Disorders
____Back and Chest Aches
____Headaches
____Leg/Foot/Shin pain
____Edema
____Vascular/Blood Disorder
____Respiratory Disorders
____Stomach Disorders
____Allergies
____Neck/ Shoulder Pain
____TMJ Syndrome
____Dentures/Implants
____Hernia/Bulging Discs
____Insomnia/Anxiety

****Please Mark below daily/weekly habits from a 1-10 scale (Least to most often)****

Client History Intake 2

Do You Smoke?_____ Drink Alcohol_____ Drink Caffeine/_____
Soda_____ Salt_____ Sugar_____ Dairy Products_____

Processed Foods_____Recreational Medical Mngmt_____
Prescription and/or Over the counter Medications _____

Please advise us of any other health care professionals you have or are seeing for this condition. Also, please list any prescription medicine you are currently taking.

_____

_____

_____

_____

If you have any other medical issues including past surgeries or injuries that I should be aware of, it is important to Please inform us before receiving a massage by describing these specific issues:

_____

_____

_____

_____

Patient Name: _____