History/Present Information

Name: Date:

Address (including zipcode):

Primary phone: Alternate phone: Birthdate:

E-mail: Emergency contact:

Occupation —or- how you generally spend a day:

Medications: For: Side effects:

Are you pregnant‘? Y N If so, how many weeks or months?

Are you being treated by a physician now or recently? Y N

Please explain (if applicable):

Referred by:

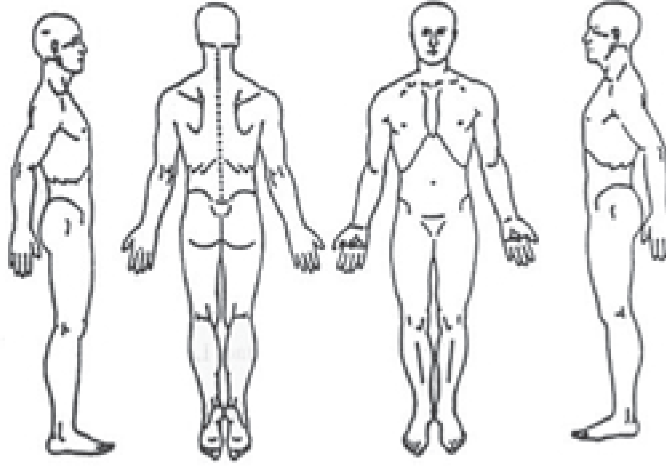
Have you previously received professional massage therapy? Y N

When was your last massage?

Can you briefly describe your experience or results?

Reason for today’s appointment. . .your intention:

Please circle areas of discomfort or pain or areas where you are aware of holding tension:



Is there painwith touch (palpation)? **With motion?**

Approximately when did you first notice?

Have you ever had any trauma or surgery? Y N

Brief description (include when):

Brief description of diet, exercise habits, lifestyle:

Please circle any of the following that have applied in the past 5 years and place an asterisk next to the ones that currently apply:

arthritis	abdominal pain	fatigue	menstrual pain	varicose veins
sciatic problems	blood clots	headache	neck pain	bursitis
broken bones	diarrhea	cancer	ringing in ears	whiplash
back pain	diabetes	hernia	shallow breath	insomnia
heart condition	edema	PMS	A1DS/ ARC/HIV	chest pain
constipation	extremities tingling	depression	recent flu	loss of balance
high blood pressure	sinus distress	dizziness	skin problems	Osteoporosis

I understand that massage therapy is not intended as a substitute for medical care. I also agree to actively participate in my own healing as I am able and that any information offered by the therapist is for educational purposes only and is not diagnostically prescriptive in nature.

Client's signature: **Date:**