CLIENT HISTORY

Name:_____ **Date:** _____

Address: _____ **Phone:** _____

_____ **DOB:** _____

Email: _____

Occupation: _____ **Emergency Name & Number:** _____

How did you hear about us? _____

Have you ever experienced a professional massage or bodywork session? _____

Primary reason for appointment? _____

Please take a moment to carefully read and mark the following information as it applies to you. If you have specific medical conditions or symptoms, massage /bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

___ Headaches/Migraines	___Tension/Stress	___Fatigue	___ Chronic Pain
___ Joint Pain	___Muscle or Bone Injuries	___Rotator Cuff Injury	___Arthritis
___Numbness or Tingling	___Trouble Sleeping	___Jaw Pain, TMJ	___Chronic Sinus Issues
___Allergy/Sensitivity	___Rashes, Athletes Foot	___Infectious Disease	___Blood Clots/Phlebitis
___Spinal Column Disorders	___Asthma, Lung Conditions	___Circulatory Problems	___Heart Attack
___Digestive Problems/Disorders	___ Hernia	___Lupus	___ High Blood Pressure
___Mental Illness	___Heart Conditions	___Fibromyalgia	___Wearing Contacts
___Wearing Dentures	___Grieving	___Bruise Easily	___Epilepsy/Seizure
___ Injuries/ Surgeries	___Diabetes Type __1__2	___Other medical conditions we should be aware of?	

If you checked any of the above, please briefly explain. We will discuss them before your massage.

_____

_____

_____

_____

_____

_____

No. of hours on computer /day _____

Activities that aggravate your pain:_____

Have you ever had cancer ? [YES] [NO] Type:_____

Date diagnosed: _____ **Time Recovered:** _____ **WBC (4.5-10):** _____ **PLT (150-450):** _____

Treatment/s:_____

Were any lymph nodes removed/irradiated? [YES] [NO] If yes, Neck [ ] Armpit [ ] Groin [ ]