CONFIDENTIAL CLIENT INFORMATION & HEALTH HISTORY FOR MEDICAL MASSAGE

PLEASE FILL OUT CLEARLY AND COMPLETELY

General Information

First Name: ____

Last Name: ____

Address: _________________________________ **Apt:** _________

City: __________________ **State:** _____________ **Zip:**__________

Current / Previous Occupation:______________________________

Date of Birth ______/_______/________

Cell Phone: (________)________________

☐ *Opt-in your cell phone to receive* ***Appointment Reminders***

Gender *(circle one)*: Male OR Female

Email: ______________________________

Emergency Contact Name: ________________________________

Relationship: ____

Phone: (________)________________

How'd you hear about us? *(So, we can give credit)*

Name: ___________________________

Relationship Status: Married OR Single

Car Accident Information

Name of your Car Insurance Company: ________________________________

Full Name of your Claims Representative/ Adjuster: ________________________________

Your Claims Representative/ Adjuster Phone #: ________________________________ **Ext:** _____________

Policy or Claims # (From Auto Accident): ________________________________

Date of Accident: ______/_______/________

Date(s) Unable to Work: ______/_______/________ to ______/_______/________

Date(s) you were Hospitalized: ______/_______/________ to ______/_______/________

Doctor Information

Are you currently under the care of a doctor?	☐Yes ☐ No
If yes, whom? *(Full Name)*: __________________________	
What is your Doctor's phone #?: ______________________	
Please list reason(s) why: ________________________________	

Attorney Information

Do you have an attorney on your case?	☐Yes ☐ No
If yes, whom? *(Full Name)*: ______________________	
What is your Attorney's phone #? _________________	
Name of your Attorney/ Law Firm Company: ________________________________	

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Health History & Pain Management Information	
What do you hope to accomplish from today's massage?: ______	
Are you aware of any tension holding spots in your body?	☐Yes ☐ No
If yes, where? *(list locations)*: ______	
Describe any surgeries, hospitalizations, accidents or injuries you ever had: ______	
What kind of care did you receive for your accidents or injuries?:______	
Do you feel that you have recovered from these events?	☐Yes ☐ No
Please explain: ______	
Do you have any chronic, ongoing pain that you deal with on a regular basis?	☐Yes ☐ No
When did it begin? *(Please explain)*: ______	
On a scale of 1-5, *(1 being minor & 5 being worse)* **How bad is the pain today?: ______** **Is the pain felt anywhere else? Where?: ______**	
Describe what activities cause this pain and/or make it worse: ______ **What makes it better:______**	
Describe the pain (i.e. sharp, dull, stabbing, achy, throbbing):______	
Are you receiving any other type of medical treatment?	☐Yes ☐ No
If yes, please explain: ______	
Please list any medication (vitamins, herbs or pharmaceutical) taken now or at regular intervals (include explanation of what medication is used to treat): ______ ______	
Are there any other health concerns you wish to discuss today?	☐Yes ☐ No
If yes, please describe:______	

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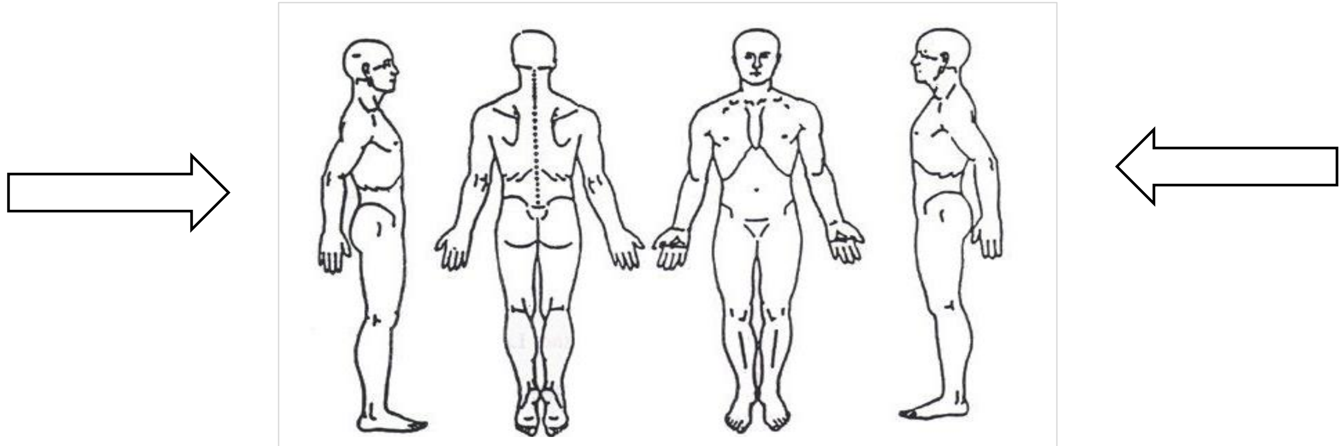
PLEASE FILL OUT CLEARLY AND COMPLETELY

Please Indicate where you Experience Pain on the Drawing



Are you currently experiencing any of the following conditions?

______ Flu or Cold _____ Inflammation _____ Fever _______ Infection ______ Contagious Disease

Please check any of the following conditions below that currently affect you or that you have experienced in the last 5 years.

	MUSCULOSKELETAL
	Fibromyalgia
	Spasms/Cramps
	Sprains/Strains
	Osteoporosis
	Postural Deviations
	Gout
	Bursitis
	Osteoarthritis/Rheumatoid Arthritis
	TMJ
	Cysts
	Plantar Fasciitis
	Tendonitis
	Torticollis
	Whiplash Syndrome
	Carpal Tunnel Syndrome
	Sciatica
	Other: ________________________

	DIGESTIVE
	Ulcers
	Irritable Bowel Syndrome
	Colitis
	Gallstones
	Hepatitis
	Crohn's Disease
	Diarrhea
	Gas/Bloating
	Other: ________________________

	RESPIRATORY
	Pneumonia
	Sinusitis
	Asthma
	Dizziness
	Trouble Breathing
	Other: _____________________

	SKIN
	Fungal Infections
	Acne
	Impetigo
	Dermatitis/Eczema
	Psoriasis
	Open Wound or Sore
	Rashes
	Warts/Moles
	Athletes Foot
	Other: _____________________

	CIRCULATORY
	Anemia
	Hemophilia
	Hypertension
	Low Blood Pressure
	Raynaud's Disease
	Varicose Veins
	Heart Condition
	Blood Clots/Phlebitis
	Diabetes

	NERVOUS SYSTEM
	ALS
	Multiple Sclerosis
	Parkinson's Disease
	Bell's Palsy
	Neuritis
	Spinal Cord Injury
	Stroke
	Trigeminal Neuralgia
	Seizure Disorders
	Numbness/Tingling/Twitching
	Other: _________________________

	OTHER
	Insomnia
	Anxiety/Panic Attacks
	PMS
	Grief Process
	Cancer
	Substance Abuse
	Pregnancy
	Chronic Fatigue
	HIV/AIDS
	Kidney Disease
	Bladder Infection
	Postoperative Situation
	Edema
	Lupus
	Other:______________________

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I understand that cancelled or missed appointments without 24 hours' notice (medical emergencies excluded) may be charged in full for the price of the missed session.

***Signature:*____ *Date:*______/______/______ *Practitioners Initials:* ________**