



Legal name: _____

Today's Date: _____

Preferred name: _____

Email: _____

Address: _____

Preferred contact method:

Preferred telephone number: _____

Telephone | Text | Email

The following questions are based on the most current understanding of gender

Assigned sex at birth: Male ___ Female ___ Intersex ___ Other ___ Decline ___

Current gender by identity: Male ___ Female ___ Intersex ___ Other ___ Decline ___

Occupation: _____ Birthdate: _____

Age: _____ Height: _____ Weight: _____

Whom may I thank for your referral? _____

What major concerns brought you here today? _____

In case of emergency, please notify: _____ Phone: _____

I, _____, (client) understand that massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation, and treatment procedures have been explained to me. I understand that bodywork is not a substitute for medical treatment or medications. I understand that the therapist does not diagnose illness, does not prescribe medication, and that spinal manipulation is not part of the therapy.

I understand it is my responsibility to inform the therapist of all known medical conditions and medication, as well as keeping the therapist informed of any changes. I understand that there shall be no liability on the part of the therapist due to my forgetting to relay any pertinent information.

I understand that it is my own responsibility to communicate with the therapist if I feel any pain or discomfort during the session so that the treatment can be adjusted.

I understand that therapeutic bodywork is NONSEXUAL in nature. Any sexual overtures by the client will result in the immediate termination of the session and the therapeutic relationship.

Client signature: _____

Date: _____

Health History

Please check the following conditions that apply to you, whether past or present.

Musculoskeletal

- Headaches
- Joint stiffness
- Spasms/cramps
- Broken bones
- Sprains
- Back/hip pain
- Shoulder/neck pain
- Arm/hand pain
- Leg/foot pain
- Chest/abdominal pain
- Jaw pain/TMJ
- Tendinitis
- Bursitis
- Osteoarthritis
- Rheumatoid arthritis
- Scoliosis
- Bone or joint disease
- Trouble walking

Circulatory and Respiratory

- Dizziness
- Shortness of breath
- COPD
- Fainting
- Cold hands/feet
- Swollen ankles
- Blood clots
- Heart failure
- Heart attack
- Sinus issues
- Asthma
- Seasonal allergies
- High blood pressure
- Low blood pressure
- Varicose veins
- Lymphedem

Skin

- Rashes
- Allergies
- Fungal infection
- Ulcers
- Warts
- Moles
- Acne
- Cosmetic surgery
- Chemical sensitivity

Digestive

- Nervous stomach
- Loss of appetite
- Hiatal hernia
- Constipation
- Diarrhea
- Fecal incontinence
- Urinary incontinence
- Diverticulitis
- Irritable bowel syndrome
- Crohn's disease
- Colitis
- Ulcers
- Urinary tract infections
- Ostomy devices

Reproductive Systems

- Current pregnancy
- Menopause
- Pelvic inflammatory disease
- Endometriosis
- Hysterectomy
- Benign prostatic hypertrophy
- Impotence
- Hormone replacement

Nervous System

- Numbness/tingling
- Migraines
- Chronic pain
- Stroke
- Fibromyalgia
- Paralysis
- Epilepsy
- MS/MD/Parkinsons
- Herpes/shingles
- Benign tremor
- Cerebral palsy
- Brain/spine injury

Other

- Forgetfulness
- Depression
- Trouble concentrating
- Hearing impaired
- Visually impaired
- Post-polio
- Cancer
- Hepatitis C
- Infectious disease
- Liver disease
- AIDS/HIV+
- Kidney disease
- Other _____
- _____

Please list all prescription and nonprescription drugs/supplements, including alcohol/nicotine use:

History of car accidents, falls, concussions, whiplash injuries and serious illnesses:

Date(s)	Incident
_____	_____
_____	_____
_____	_____

In general, how is your health?

What are your major stressors?

Any history of cancer?

Have you had any surgeries?

Date(s)	Surgery
_____	_____
_____	_____
_____	_____

Anything else I need to know?

I have stated all conditions that I am aware of and this information is true and accurate.

Clients initials: _____

Date: _____