**Client Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **What are you hoping to gain from massage?**

|  |
| --- |
|  |

1. **Have you ever had a professional massage/bodywork? Yes\_\_\_\_\_ No\_\_\_\_\_**

|  |  |
| --- | --- |
| **If so, what kind(s)?** |  |

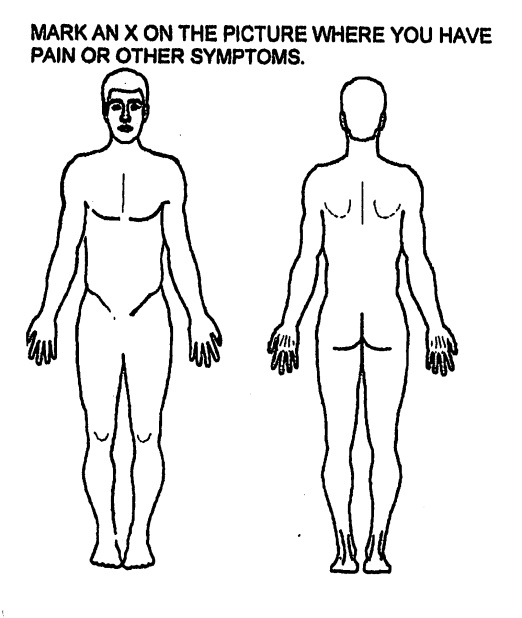
1. **Are you presently under a doctor’s or therapist’s care? Yes\_\_\_\_\_ No\_\_\_\_\_**
2. **Please list current symptoms\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **Please list any medications you are taking\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What side effects, if any, do you experience?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Do you smoke? Yes\_\_\_\_\_ No\_\_\_\_\_**
2. **Do you have any allergies? Yes\_\_\_\_\_ No\_\_\_\_\_**

**If so, to what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Do you wear contact lenses? Yes\_\_\_\_\_ No\_\_\_\_\_**
2. **Are you pregnant? Yes\_\_\_\_\_ No\_\_\_\_\_ If so, what is your due date?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **What kind of exercise do you do regularly?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Are you experiencing any pain today? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, how long have you had this pain?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please mark the amount of pain sensation and

unpleasantness on the scales below:

*Pain sensation: how much pain you feel physically in your body*

0\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_10

No Pain Most Pain Possible

*Pain unpleasantness: how much the pain in your body bothers you*

0\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_10

No Unpleasantness Most Possible Unpleasantness

Please check any of the following conditions which you currently have or have experienced in the past. Some may be contraindications for massage. Massage is not designed to treat the following conditions but information will help us to plan the session.

***Systemic Infections***

* Mononucleosis
* Flu
* Hepatitis
* Fever
* Other Virus\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Cardiovascular***

* Varicose Veins
* Phlebitis
* Stroke
* Blood Clots
* Acute Inflammation
* Heart Attack
* Heart Disease
* High Blood Pressure
* Low Blood Pressure
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Musculoskeletal***

* Whiplash
* Low Back Pain
* Strain/Sprain
* Fracture
* Osteoporosis
* Scoliosis
* Arthritis
* Foot Pain
* Torn Ligaments/ Cartilage/Tendons
* Sports Injuries
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Neurological***
* Sciatica
* Headaches
* Slipped disc
* Numbness/Weakness/ Coldness in Limbs
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Skin Infections***

* Eczema
* Burns
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Endocrine***

* Diabetes
* Hypoglycemia
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Respiratory***

* Emphysema
* Hay Fever
* Asthma
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Reproductive***

* Menstrual Cramps
* PMS
* Prostatitis
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Digestive***

* Constipation
* Diarrhea
* Colitis
* Crohn’s Disease
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Urinary***

* UTIs
* Frequent Urination
* Difficult/Painful Urination

***Psychiatric***

* Mood Swings
* Sleep Disorders
* Exhaustion
* Depression
* Acute Anxiety
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Cancer:** *Please describe* | |  | |
| *type and stage, with dates* | |  | |
| **Surgery:** *Please* |  | | |
| *describe with dates* |  | | |
| **Miscellaneous:** *Please describe* | | |  |
| *any other conditions (Include dates)* | | |  |