Massage Therapy History

Case # _____Date_____

We would like to make your massage therapy session as pleasant and comfortable as possible. Please be sure to arrive a few minutes early so you don't feel rushed. Scheduled massage times include time for disrobing (to your comfort level) and dressing after the massage. The following information will be helpful plan a safe and effective massage session.

Client Information

Full Name _____ Nickname _____

Address _____ City _____ State _____ Zip _____

Sex: ☐ M ☐ F Age: _____ Birth date: ____/_____/____ E-mail address: _____

Home Phone: (_____) _____Work Phone: (_____) _____ Cell Phone: (_____)_____

Occupation/Employer: _____

How did you hear about our clinic? _____

Are you currently under chiropractic care? ☐ No ☐ Yes If yes, are you a patient of Life Refined? ☐ Yes ☐ No

Emergency contact name: _____ Phone: (_____) _____

Massage Information & Health Questions

Everyone reacts differently to massage therapy. During your massage, it is normal to feel the need to move or change position, sigh, yawn, or have a change in breathing pattern, experience stomach gurgling or the movement of intestinal gas, experience emotional feelings (crying), or fall asleep. After your massage, it is not unusual to experience muscle soreness from the toxins released during your session. It is extremely important to hydrate with water before and after your massage to help reduce this effect.

What is the purpose for you seeking massage therapy today? _____

Have you ever had a professional massage before? ☐ Yes ☐ No

If yes, how often do you receive massage therapy? _____

If yes, when was your last massage? _____

If yes, what kind of massage? ☐ Swedish ☐ Deep Tissue ☐ Sports ☐ Pregnancy ☐ Other: _____

Do you have any allergies to oils, lotions or ointments? ☐ Yes ☐ No

If yes, please explain: _____

Do you have sensitive skin? ☐ Yes ☐ No

If yes, please explain: _____

Are you wearing: Contact Lenses? ☐ Yes ☐ No Dentures? ☐ Yes ☐ No Hearing Aid? ☐ Yes ☐ No

Do you have any difficulty lying on your front, back or side? ☐ Yes ☐ No

If yes, please explain: _____

Do you sit for long hours at a workstation, computer or driving? ☐ Yes ☐ No

If yes, please describe: _____

Do you perform any repetitive movement in your work, sports or hobby? ☐ Yes ☐ No

If yes, please describe: _____

Do you experience stress in your work, family, or other aspect of your life? ☐ Yes ☐ No

If yes, how do you think this stress is affecting your health? ☐ Mild ☐ Moderate ☐ Severe

Is stress affecting any of the following? ☐ Muscle Tension ☐ Anxiety ☐ Insomnia ☐ Other: _____

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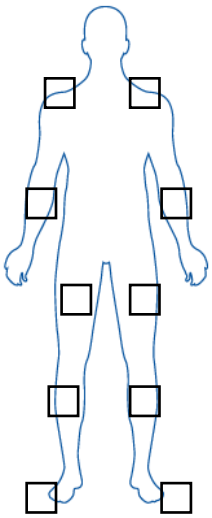
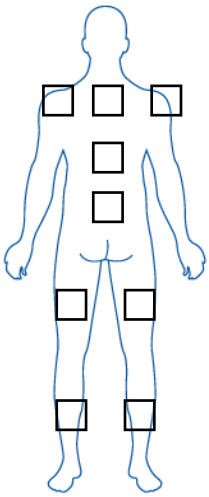
Are there any particular areas of the body where you would like your massage therapist to concentrate? ☐ Yes ☐ No

If yes, please mark the areas on the diagrams below.

Front



Back



Health History Overview

Are you currently taking any prescription medications? ☐ Yes ☐ No

If yes, please list the name and reason for medications: _____

_____

_____

Are you currently under the care of a medical professional for any conditions?

- ☐ contagious skin condition
- ☐ open sores or wounds
- ☐ easy bruising
- ☐ recent accident or injury
- ☐ recent fracture
- ☐ recent surgery
- ☐ artificial joint
- ☐ sprains / strains
- ☐ current fever
- ☐ swollen glands
- ☐ allergies / sensitivity
- ☐ heart condition
- ☐ high or low blood pressure
- ☐ circulatory disorder
- ☐ atherosclerosis
- ☐ phlebitis
- ☐ deep vein thrombosis / blood clots / varicose veins
- ☐ joint disorder / rheumatoid arthritis / osteoarthritis / tendonitis
- ☐ osteoporosis
- ☐ epilepsy
- ☐ headaches/migraines
- ☐ cancer
- ☐ diabetes
- ☐ decreased sensation
- ☐ back / neck problems
- ☐ Fibromyalgia
- ☐ TMJ
- ☐ carpal tunnel syndrome
- ☐ blood disorders (hemophilia, clotting disorder, etc.)
- ☐ pregnancy If yes, estimated due date?_____

Consent for Care

I, the undersigned, understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for care from a primary healthcare practitioner. I understand that massage should not be performed under certain medical conditions, and I affirm that I have answered all questions about my health and any medical conditions truthfully. I also understand that payment is due at the time of service, that I am responsible for payment of any missed appointments and arriving late for scheduled appointments will incur the full fee, with the massage session lasting for the remaining time of the scheduled session.

Signature: _____ Date: _____