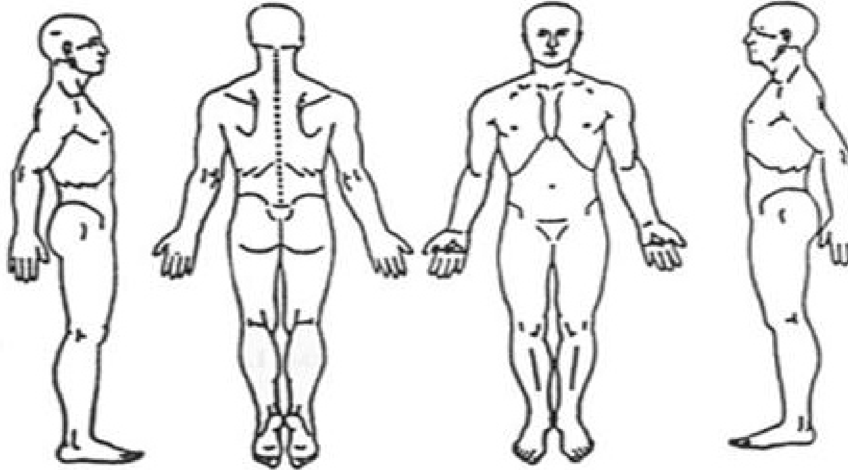
Client Information -- Joy of Healing Massage Therapy

Name: ______________________ Email: ______________________
Home Phone: ______________________ Cell Phone: ______________________
Address: ______________________
City: ______________________ State: __________ ZIP: __________
Date of Birth: ______________________ Occupation: ______________________
Emergency Contact: ______________________ Phone: ______________________
How were you referred to our office? ______________________

The following information will be used to help plan safe and effective massage sessions.
Please answer the questions to the best of your knowledge. Date of first visit: ______________________

1. Have you had a professional massage before? Yes ☐ No ☐
   If yes, how often do you receive massage therapy? ______________________
2. Do you have any difficulty lying on your front, back or side? Yes ☐ No ☐
   If yes, please explain ______________________
3. Do you have any allergies to oils, lotions or ointments? Yes ☐ No ☐
   If yes, please explain ______________________
4. Do you have any other allergies (i.e. foods, environmental allergens, etc.)? Yes ☐ No ☐
   If yes, please explain ______________________
5. Do you have sensitive skin or any skin conditions (currently or previously)? Yes ☐ No ☐
   If yes, please explain ______________________
6. Are you wearing: contact lenses ☐ dentures ☐ a hearing aid ☐ ?
7. Do you sit for long hours at a workstation, computer or driving? Yes ☐ No ☐
   If yes, please explain ______________________
8. Do you perform any repetitive movement in your work, sports or hobby? Yes ☐ No ☐
   If yes, please explain ______________________
9. Do you experience stress in your work, family or other aspect of your life? Yes ☐ No ☐
   If yes, how do you think it has affected your health? Muscle tension ☐ Insomnia ☐ Irritability ☐
   Other______________________
10. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?
    Yes ☐ No ☐ If yes, please identify ______________________
11. When did this condition begin/when did you first notice it? ______________________
    Describe______________________
12. Do you have any particular goals in mind for this massage session? Yes ☐ No ☐
    If yes, please explain ______________________
13. Is the purpose of this visit related to an auto accident or work injury? Yes ☐ No ☐
    Describe______________________
14. Date of accident or work injury, if applicable ______________________
15. What activities aggravate your symptoms? ______________________
16. Is there anything that has relieved your symptoms? Yes ☐ No ☐
    Describe______________________
17. Do you exercise? Yes ☐ No ☐ How often? ______________________
    What activities? ______________________
18. Do you smoke? Yes ☐ No ☐ How much? ______________________
19. Do you drink coffee? Yes ☐ No ☐ How much per week? ______________________
20. Do you take any supplements (i.e. vitamins, minerals, herbs)? If so, please list ______________________
    ____

Circle any specific areas you would like the massage therapist to concentrate during the session.



Medical History:

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

1. Are you currently under medical supervision? Yes ☐ No ☐

   If yes, please explain ______________________________

2. Do you see a chiropractor? Yes ☐ No ☐ If yes, how often? ______________________________

3. Are you currently taking any prescription medication? Yes ☐ No ☐

   If yes, please list ______________________________

4. Please check any current and previous conditions listed below that apply to you (please circle condition that applies if more than one list per line).

- ☐ Neck pain
- ☐ Pain in shoulders/arms/hands
- ☐ Numbness/tingling in arms/hands
- ☐ Coldness in hands
- ☐ Hearing disturbances
- ☐ Weakness in grip
- ☐ Middle back pan
- ☐ Pain into ribs/chest
- ☐ Lower back pain
- ☐ Pain into your hips/legs/feet
- ☐ Weakness/injuries to hips/knees/ankles
- ☐ Swollen ankles
- ☐ Numbness/tingling in legs/feet
- ☐ Coldness in legs/feet
- ☐ Muscle cramps in legs/feet
- ☐ Contagious skin condition
- ☐ Rashes
- ☐ Open sores or wounds
- ☐ Easy bruising
- ☐ Recent accident or injury
- ☐ Recent surgery
- ☐ Artificial joint
- ☐ Sprains or strains
- ☐ Current fever
- ☐ Swollen glands
- ☐ Allergies/sensitivity
- ☐ Sinusitis
- ☐ Headaches/migraines
- ☐ Recurrent colds/flu
- ☐ Dizziness
- ☐ Visual disturbances
- ☐ Insomnia
- ☐ Heart attacks/angina
- ☐ High or low blood pressure
- ☐ Circulatory disorder
- ☐ Varicose veins
- ☐ Atherosclerosis
- ☐ Phlebitis
- ☐ Deep vein thhrombosis
- ☐ Blood clots
- ☐ Heart murmurs
- ☐ Heart palpitations
- ☐ Thyroid condition
- ☐ Low energy/fatigue
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Tendonitis
- ☐ Epilepsy
- ☐ Broken/dislocated bones
- ☐ Cancer
- ☐ Diabetes
- ☐ Stroke
- ☐ Indigestion
- ☐ Heartburn
- ☐ Scoliosis
- ☐ TMJ/jaw pain/clicking
- ☐ Asthma
- ☐ Carpal tunnel syndrome
- ☐ Tennis elbow
- ☐ Pregnancy, ____ months

Please explain any condition that you have marked on the previous page ______________________________

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5. Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you? ___________________________________

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Who Is Responsible for Charges on Your Account?

Patient ☐ Spouse ☐ Parent/Guardian ☐ Auto Insurance (PIP) ☐ Workers Comp/L&I ☐

Insurance Company & Address: ____

Claim Number: ______________________________ Date of Accident: ___________________________

Adjuster's Name: ____________________________ Phone: ___________________________________

Agreement for Massage Care:

I, ______________________________________ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this massage session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment and that I understand that massage therapists are not qualified to perform spinal or skeletal adjustment, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the massage session given should be construed as such.

Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the massage session and I will be liable for payment of the scheduled massage session. I also understand that the Licensed Massage Therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

Signature of Client/Patient: ______________________________________ Date: ____________________

Signature of Massage Therapist: ___________________________________ Date: ____________________