Health Information

Client Contact Information

Client Name: _____ Date: _____

Date of Birth: _____ Gender: _____

Address: _____

Phone: _____ Email: _____

Referred by: _____

Emergency contact: _____ Phone: _____

Physician/Health-care Provider name: _____ Phone: _____

Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes ☐ No ☐

Do you have a physician referral/prescription? Yes ☐ No ☐

Are you seeking insurance reimbursement? Yes ☐ No ☐ If yes, please complete the Billing Information form.

Type of insurance coverage for this claim: Car Collision Worker's Compensation Private Health

Massage Information

Have you ever received professional massage/bodywork before? Yes ☐ No ☐

How recently? _____

What types of massage/bodywork do you prefer? _____

What kind of pressure do you prefer? Light Medium Firm

What are your goals/expected outcomes for receiving massage/bodywork?

_____

_____

How do you feel today? _____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

_____

_____

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No

Explain:

_____

_____

List the medications you currently take:

_____

_____

Are you wearing contacts? Yes ☐ No ☐

Are you wearing dentures? Yes ☐ No ☐

Are you wearing a hairpiece? Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐

Health Information

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment?

_____

Circle any of the following health conditions that you currently have (If you are unsure, please ask):
blood clots, infections, congestive heart failure, contagious diseases, pitted edema
Please answer honestly, as massage may not be indicated for the above conditions.

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

Current Past Muscle or joint pain _____
Current Past Muscle or joint stiffness _____
Current Past Numbness or tingling _____
Current Past Swelling _____
Current Past Bruise easily _____
Current Past Sensitive to touch/pressure _____
Current Past High/Low blood pressure _____
Current Past Stroke, heart attack _____
Current Past Varicose veins _____
Current Past Shortness of breath, asthma _____
Current Past Cancer _____
Current Past Neurological (e.g. MS, Parkinson's, chronic pain) _____
Current Past Epilepsy, seizures _____
Current Past Headaches, Migraines _____
Current Past Dizziness, ringing in the ears _____
Current Past Digestive conditions (e.g. Crohn's, IBS) _____
Current Past Gas, bloating, constipation _____
Current Past Kidney disease, infection _____
Current Past Arthritis (rheumatoid, osteoarthritis) _____
Current Past Osteoporosis, degenerative spine/disk _____
Current Past Scoliosis _____
Current Past Broken bones _____
Current Past Allergies _____
Current Past Diabetes _____
Current Past Endocrine/thyroid conditions _____
Current Past Depression, anxiety _____
Current Past Memory Loss, confusion, easily overwhelmed _____

Comments:

_____

_____

Client Signature: _____ Date: _____
Parent or Guardian Signature (in case of a minor): _____ Date: _____