Complete Health Center
Massage Client Information Form

Date: ______________________________

Name: __________________________________ Date Of Birth: ______________ Gender: Male/Female

Address: ________________________________ City/State/Zip: __________________________________

Home Phone: ____________________________ Work/Cell Phone: _______________________________

Email: __________________________________ Occupation: ___________________ Age: _______

Emergency Contact Name: ____________________________________ Phone Number: ______________________

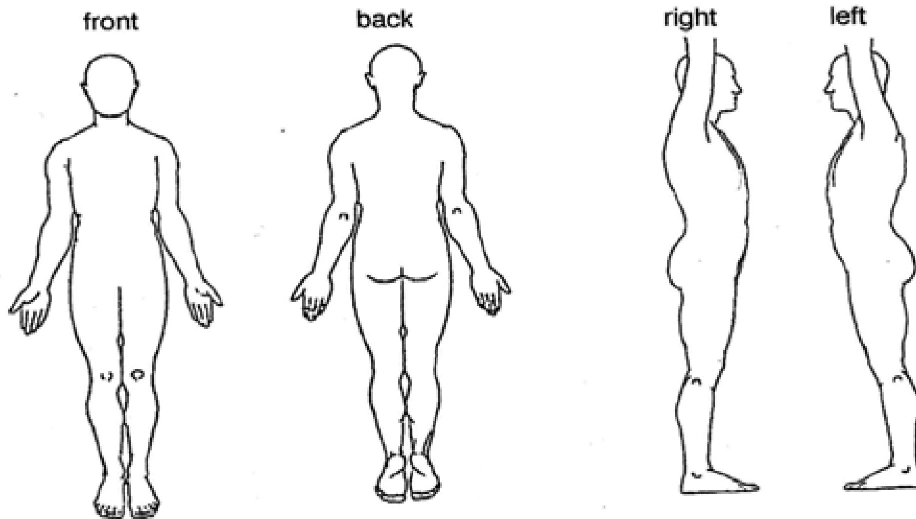
Physician: _______________________________ Referred by: ____

MEDICAL INFORMATION

Yes No *Have you had a massage before? If yes, how recently?* ______________________________
Yes No *Do you frequently suffer from stress?*
Yes No *Do you have diabetes?*
Yes No *Do you experience frequent headaches? How Often?* ________________________________
Yes No *Are you pregnant? How Far Along?* ____
Yes No *Do you suffer from arthritis? Where:* ____
Yes No *Are you wearing dentures?*
Yes No *Do you have high blood pressure? If yes, do you take medication? Yes / No*
Yes No *Do you suffer from epilepsy or seizures?*
Yes No *Do you suffer from joint swelling? Where:* ____
Yes No *Do you have varicose veins?*
Yes No *Do you have any contagious diseases?*
Yes No *Do you have osteoporosis?*
Yes No *Do you have any allergies? Please List:* ____
Yes No *Do you have any skin conditions? Explain:* ____
Yes No *Do you bruise easily? Where?* ____
Yes No *Have you had any broken bones in the past two years? Please list:* ___________________
____
Yes No *Have you been in an accident or suffered any injuries in the past two years? Please explain:* ____
Yes No *Do you have cardiac or circulatory problems?*
Yes No *Do you suffer from neck or back pain?*
Yes No *Do you have numbness or stabbing pains? Where?* _________________________________
Yes No *Are you very sensitive to touch or pressure in any area? Where?* ____________________
Yes No *Have you ever had surgery? Please explain:* _______________________________________
Yes No *Do you have, or have you ever had, cancer?*
Yes No *Do you have any other medical condition or are you taking any medications I should know about?* ____
____
Yes No *Do you have tension or soreness (including sprains/strains) in a specific area? Please specify:* ____
Yes No *Do you exercise? Please list activities, frequency, and intensity:* ______________________
____
Yes No *Do you have other concerns your massage therapist should be aware of? Please explain:*
____

Turn Over Please

BODY MAP
Please complete the body map using the symbols below.
X – Areas I do NOT want massaged
O – Areas that need extra attention (pain, tension, or concern)



What are your expectations and/or goals of massage therapy?
____

RELEASE
Please read carefully and sign below.
I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. Techniques may include Swedish, deep tissue, trigger point, hot stone, and/or myofascial release. Modest draping will be utilized. All body parts may be addressed, except genital and breast areas. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I also may request that the session be discontinued at any time, for any reason, and the therapist will honor that request.

I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork 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 also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature: ________________________________ Date: ___________________
Therapist Signature: ______________________________ Date: ___________________

Consent to Treatment of Minor: By my signature below, I hereby authorize _______________________ to administer massage/bodywork or somatic therapy techniques to my child or dependent as they deem necessary.
Signature of Parent or Guardian: ______________________________ Date: ___________________