Confidential Client History

Name: ____

Address: ____

Post Code: ____________________________ Mobile: _________________________________

Phone (W): ____________________________ Phone (H): ________________________________

Occupation: ____________________________ D.O.B: ________________________________

Email: ____

Lifestyle Habits – alcohol/eating habits/emotions/leisure activities/poor sleep/smoker/water consumption etc.

Please describe in your own words – eg/ play golf, 2 drinks per day, feel stressed, etc.

____

____

____

Emergency Contact: _______________________________ Phone: _______________________________

Referred by/how did you hear about us? ____

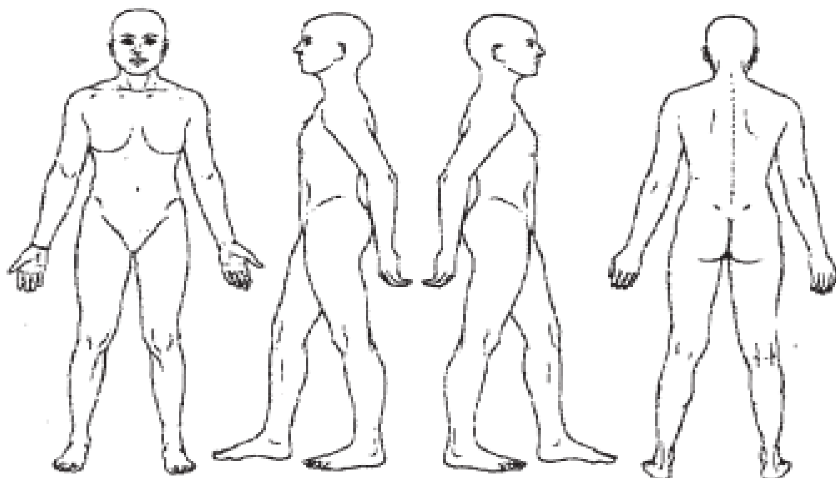
Have you had a massage before? ☐Yes ☐No

Do you experience any difficulty lying on your front? ☐ Yes ☐No

Do you experience any difficulty lying on your back? ☐ Yes ☐ No

Are you allergic is massage oil? Or any other allergies____

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



Please tick (✓) all conditions that apply now. Put a (P) for past conditions.

- ___ Heart, circulatory problems
- ___ High/low blood pressure
- ___ Varicose veins
- ___ Blood clots
- ___ Phlebitis
- ___ Infectious disease
- ___ Skin disorders
- ___ Allergies
- ___ Cancer and/or tumours
- ___ Asthma or lung conditions
- ___ Hernias
- ___ Abdominal or digestive problems
- ___ Arthritis/Arthrosis/ joint pain
- ___ Numbness and tingling
- ___ Muscle/bone injuries
- ___ Chronic pain
- ___ Fatigue
- ___ Headaches or migraines
- ___ Stroke
- ___ Seizures
- ___ Depression
- ___ Pregnancy
- ___ Hearing problems
- ___ Motor vehicle accident
- ___ Fibromyalgia
- ___ Prosthesis or dentures
- ___ Vision problems or contact lenses

Other medical conditions or injuries not listed:

____

____

Current medications, including aspirin, ibuprofen, herbs, vitamins, etc:

____

____

Surgeries: ____

____

____

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Presentation

Current symptoms/location and duration or onset

History of presenting complaint (how it happened/position/direction etc.)

____

____

Type of pain – constant/with movement/with activity/sharp/shooting/dull/aching etc.

____

____

Aggravating factors – activities/posture/stresses etc.

____

____

Relieving factors – movement/rest/posture/heat/cold/etc.

____

____

Doctor's name: ____________________________ Doctor's contact phone: ____________________________

Treatment Goals – what would you like to get out of the treatment?

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____

I understand that it is not the role of my massage therapist to diagnose injury or illness, or prescribe medications. I acknowledge that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see primary health care provider for that service.

I have stated all medical conditions of which I am aware and will update my massage therapist of any changes in my health status.

Signature: ___________________________ Date: ___________________________________