

**MASSAGE CLIENT INFORMATION**

PLEASE PRINT LEGIBLY AND FILL IN ALL THE BLANKS

Initial Appointment date: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Email (office use only) \_\_\_\_\_

Occupation: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: \_\_\_\_\_

How did you hear about us, Referred by? \_\_\_\_\_

What is your reason for coming to see us today? \_\_\_\_\_

Where exactly is the area of discomfort? \_\_\_\_\_

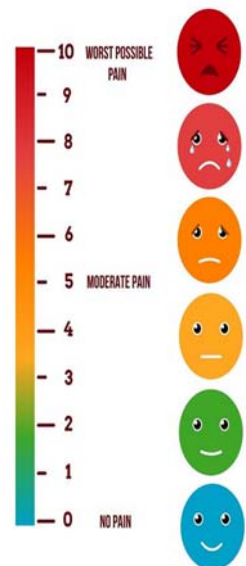
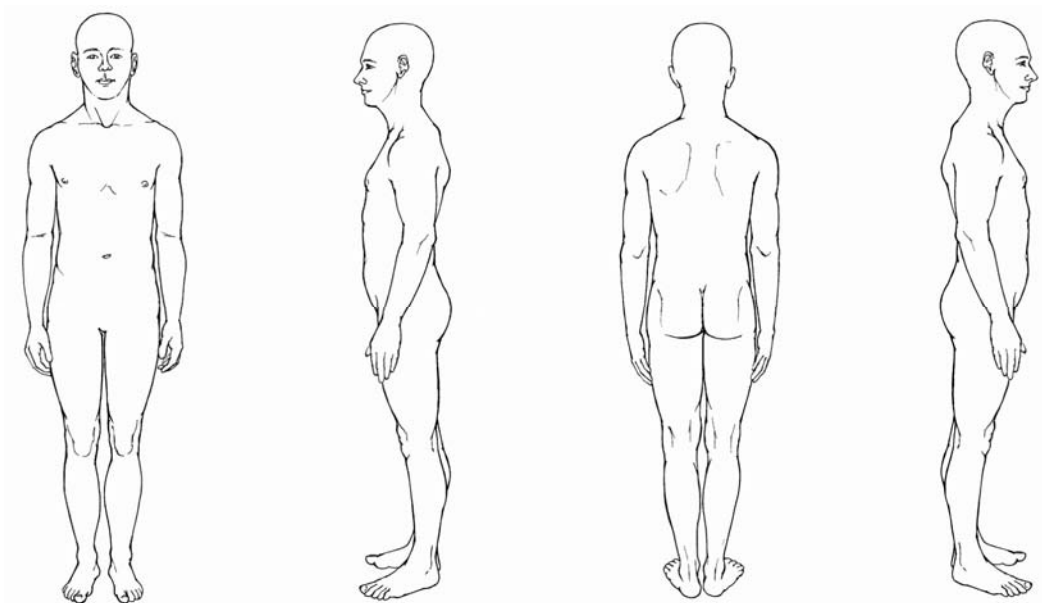
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Click on the figure below to specify your pain and tight areas.

Rate the recent level of pain (by putting a check mark next to the chart 1 – 10)

Has it been getting Better or Worse?

What does your discomfort feel like? aching cramping dull sore deep sharp shooting  
stabbing sting tingling burning numbness radiating



R bottom foot L bottom foot

# HEALTH HISTORY

## General

Current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	headaches_____
<input type="checkbox"/>	<input type="checkbox"/>	migraines_____
<input type="checkbox"/>	<input type="checkbox"/>	fatigue_____
<input type="checkbox"/>	<input type="checkbox"/>	infections_____
<input type="checkbox"/>	<input type="checkbox"/>	fever_____
<input type="checkbox"/>	<input type="checkbox"/>	sinus_____
<input type="checkbox"/>	<input type="checkbox"/>	other_____

## Muscles and Joints

Current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	rheumatoid arthritis_____
<input type="checkbox"/>	<input type="checkbox"/>	osteoarthritis_____
<input type="checkbox"/>	<input type="checkbox"/>	scoliosis_____
<input type="checkbox"/>	<input type="checkbox"/>	bone fracture_____
<input type="checkbox"/>	<input type="checkbox"/>	broken bones_____
<input type="checkbox"/>	<input type="checkbox"/>	spinal problems_____
<input type="checkbox"/>	<input type="checkbox"/>	disk problems_____
<input type="checkbox"/>	<input type="checkbox"/>	bursitis_____
<input type="checkbox"/>	<input type="checkbox"/>	joint pain_____
<input type="checkbox"/>	<input type="checkbox"/>	TMJ, jaw pain_____
<input type="checkbox"/>	<input type="checkbox"/>	spasms, cramps_____
<input type="checkbox"/>	<input type="checkbox"/>	sprains, strains_____
<input type="checkbox"/>	<input type="checkbox"/>	tendonitis_____
<input type="checkbox"/>	<input type="checkbox"/>	muscle stiffness_____
<input type="checkbox"/>	<input type="checkbox"/>	swelling_____
<input type="checkbox"/>	<input type="checkbox"/>	inflammation_____
<input type="checkbox"/>	<input type="checkbox"/>	neck pain_____
<input type="checkbox"/>	<input type="checkbox"/>	shoulder pain_____
<input type="checkbox"/>	<input type="checkbox"/>	arm pain_____
<input type="checkbox"/>	<input type="checkbox"/>	low back pain_____
<input type="checkbox"/>	<input type="checkbox"/>	hip pain_____
<input type="checkbox"/>	<input type="checkbox"/>	leg pain_____
<input type="checkbox"/>	<input type="checkbox"/>	other_____

## Skin Conditions

Current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	rashes_____
<input type="checkbox"/>	<input type="checkbox"/>	athlete's foot, warts_____
<input type="checkbox"/>	<input type="checkbox"/>	other_____

## Endocrine System

Current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	thyroid_____
<input type="checkbox"/>	<input type="checkbox"/>	diabetes_____

## Reproductive System

Current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	pregnancy_____
<input type="checkbox"/>	<input type="checkbox"/>	painful emotional menses_____

## Cancer/Tumors

Current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	benign_____
<input type="checkbox"/>	<input type="checkbox"/>	malignant_____

## Nervous System

Current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	sensitive to pressure_____
<input type="checkbox"/>	<input type="checkbox"/>	dizziness_____
<input type="checkbox"/>	<input type="checkbox"/>	ringing in ears_____
<input type="checkbox"/>	<input type="checkbox"/>	numbness, tingling_____
<input type="checkbox"/>	<input type="checkbox"/>	sciatica, shooting pain_____
<input type="checkbox"/>	<input type="checkbox"/>	chronic pain_____
<input type="checkbox"/>	<input type="checkbox"/>	depression_____
<input type="checkbox"/>	<input type="checkbox"/>	other_____

## Allergies

Current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	scents, oils, lotions_____
<input type="checkbox"/>	<input type="checkbox"/>	detergents_____
<input type="checkbox"/>	<input type="checkbox"/>	other_____

## Respiratory, Cardiovascular

Current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	heart disease_____
<input type="checkbox"/>	<input type="checkbox"/>	blood clots_____
<input type="checkbox"/>	<input type="checkbox"/>	stroke_____
<input type="checkbox"/>	<input type="checkbox"/>	lymphedema_____
<input type="checkbox"/>	<input type="checkbox"/>	high, low blood pressure_____
<input type="checkbox"/>	<input type="checkbox"/>	irregular heart beat_____
<input type="checkbox"/>	<input type="checkbox"/>	poor circulation_____
<input type="checkbox"/>	<input type="checkbox"/>	pacemaker_____
<input type="checkbox"/>	<input type="checkbox"/>	varicose veins_____
<input type="checkbox"/>	<input type="checkbox"/>	chest pain, shortness of breath_____
<input type="checkbox"/>	<input type="checkbox"/>	asthma_____

## Digestive/Elimination System

Current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	bowl problems_____
<input type="checkbox"/>	<input type="checkbox"/>	gas/bloating_____
<input type="checkbox"/>	<input type="checkbox"/>	bladder, kidney, prostate_____
<input type="checkbox"/>	<input type="checkbox"/>	abdominal pain_____
<input type="checkbox"/>	<input type="checkbox"/>	other_____

## Habits

Current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	tobacco_____
<input type="checkbox"/>	<input type="checkbox"/>	alcohol_____
<input type="checkbox"/>	<input type="checkbox"/>	coffee, soda_____
<input type="checkbox"/>	<input type="checkbox"/>	other_____

LOW LEVEL LASER, ULTRASOUND, and (DMS) DEEP MUSCLE STIMULATOR, RAPID RELEASE		
YES	NO	CONTRAINDICATIONS
		Have you had/have cancer (tumors or cancerous areas)?
		Do you have any photo sensitivities?
		Are you currently pregnant or nursing?
		Do you have a pacemaker?
		Are you taking any - Immune suppressive drugs?
		Are you taking any - Anticoagulants?
		Are you taking any - Anti-inflammatory medications?
		Have you had a cortisone or Botox shot in the last 30 days?
		Do you have any bones that are fractured at the moment? How long ago?
		Have you had surgery that added pins, screws, plates, or anything else?

## INFORMATION ABOUT THE AREA OF DISCOMFORT

What were you doing that created the discomfort? \_\_\_\_\_

When did the injury or discomfort happen? \_\_\_\_\_

Have you had the same injury or discomfort before? \_\_\_\_\_

Was the onset (Sudden or Gradual)? \_\_\_\_\_

What movements were you doing at the time of injury? \_\_\_\_\_

How often does it bother you (constantly, daily, weekly, monthly)? \_\_\_\_\_

How long does it last once you start feeling the discomfort? \_\_\_\_\_

What specifically makes it worse? (Certain movements/activities, stress, time of day, resting, no pattern)

Explain: \_\_\_\_\_

What makes it feel better? (Certain movements/activities, heat/ice, time of day, therapies, resting, nothing helps)

Explain: \_\_\_\_\_

Have you tried other therapies/remedies?      Yes      No      and did they help?      Yes      No

Explain: \_\_\_\_\_

Have you ever had a surgery?      Yes      No      and was the surgery successful?      Yes      No

Explain: \_\_\_\_\_

List any other health problems for which you are being treated to help me with a massage strategy:

\_\_\_\_\_

Current Medications: (including aspirin, ibuprofen, etc.) This will help me know what techniques to use.

\_\_\_\_\_

### MESSAGE INFORMATION

How much pressure do you prefer with massage?      Light      Medium      Firm pressure

Is there a type of massage that you prefer: \_\_\_\_\_

Do you want a full body massage or do you want me to focus on the injury site and muscles that will affect the injury?      Full body massage      Muscles affecting the Injury Site

## ACTIVITIES OF DAILY LIVING

In this section, the idea is to get a sense of what type of movements and to what intensity and frequency of activities/movements, postures/positions, and exercise you get on a regular basis.

Do these symptoms interfere with your activities of daily living (sleep, exercise, work, etc.)? [ ] Yes [ ] No

Explain: \_\_\_\_\_

Job/Work Duties: \_\_\_\_\_

Household Duties: \_\_\_\_\_

Regular Activities/Hobbies: \_\_\_\_\_

Exercise: \_\_\_\_\_

Sleeping Position: \_\_\_\_\_

Do you have difficulty lying on your: stomach back side

Do you believe it is possible to heal 100%? If not, what percentage? \_\_\_\_\_

How long do you feel it will take? \_\_\_\_\_

The level of stress you are experiencing on a regular basis, on a scale of 1 to 10. \_\_\_\_\_

(1 being the lowest): (mild 1-3, moderate 4-7, severe 8 – 10)

## Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/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 (DMS) deep muscle stimulator, and Rapid Release given here is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation and energy flow. I understand that massage/bodywork practitioners 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. Understanding all of this, I give my consent to receive care.

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

Signature (Guardian if under 18) \_\_\_\_\_