

Client

Name (last, first, MI):

Check all that apply (current or past)

- Surgery
- Diabetes
- Blood clots
- Stroke
- Heart conditions
- Cancer or tumors
- Accident, injury or whiplash
- High or low blood pressure
- Kidney conditions
- Hepatitis (A, B, C, other)
- Skin conditions
- Infectious or contagious disease
- Auto-immune condition
AIDS, fibromyalgia, chronic fatigue, lupus, etc

- Arthritis
- Broken or dislocated bones
- TMJ conditions
- Stress
- Depression
- Headaches
- Osteoporosis
- Chronic pain
- Back conditions
- Tendonitis
- Seizures or epilepsy
- Varicose veins
- Scoliosis

- Joint pain or swelling
- Gastrointestinal conditions
- Allergies (environmental or other)
- Numbness or tingling
- Muscle strain or sprain
- Sensitivity to touch
- Reactions to skin care products
- Bruise easily

Women

- Pregnancy (confirmed or suspected)
- Endometriosis
- Painful menstruation

Further details for checked items:

Pregnancy

Due date:

List complications with this pregnancy (if none, so state):

Current week:

Occupation and other activities

Check those which occur as part of your work or other, frequent activity.

- Prolonged sitting
- Prolonged walking or running
- Repetitive lifting
- Prolonged standing
- Prolonged driving
- Repetitive motion (keyboard, etc)
- Repetitive compromising postures (crawling, squatting, twisting, neck craning, stooping, hunched over, weight on knees, etc)

Describe:

Current treatments

Describe any additional, current treatments you are receiving. (rehabilitation, acupuncture, physical therapy, chiropractic, etc)

Agreement

By my signature below, I agree to the following statement(s):

1. Certain medical conditions, whether acute or chronic, may limit my eligibility for certain therapies or possibly preclude me from massage/bodywork altogether. Items listed in the shaded area above will usually require clearance from a physician.
2. My responses to all questions on this form must be truthful and forthcoming so that a proper determination may be made regarding what types of therapy to administer and/or avoid, thereby protecting my health and safety.
3. Information contained on this form will never be released to or viewed by any third party for any reason without my prior written consent.

Signature

Date: