Client Profile and Medical History

Personal Information **Date** __________________

Name _______________________________________ Date of Birth ____________ Gender ____________________
Address ____ City/State/Zip ______________________________
Phone (primary) __________________ Email ______________________________ Preferred communication (circle):
Phone Email Text
Occupation ____
Primary Physician_____________________________________ Date of last physical ___________________________
Emergency Contact ______________________ Relationship ______________ Phone _______________________
How did you hear about us? Referred by ____

Medical History

Are you currently seeing a physician or medical professional on a regular basis (other than annual physicals)? Yes No
If yes, please explain: _________________________

Have you ever been diagnosed with COVID-19 or other communicable disease? Yes No
If yes, explain and include date of diagnosis:
____

Are you taking any medications? Yes No
If yes, please list name and use: ________________
____

Are you currently pregnant? Yes No

What are your exercise habits? _________________
____

Please list all recent or previous surgical procedures, including dates: ____________________________

Do you suffer from chronic pain? Yes No
If yes, explain: ______________________________

Please describe any recent or previous history of orthopedic injury?
Area injured _________________________________
Date of injury_________________________________

Have you suffered recent or previous traumatic brain injury/concussion? Yes No
If yes, explain: _______________________________

Have you suffered injury to the spine or do you have any known vertebral/disc problems? Yes No
If yes, explain: _______________________________

Check any of the following conditions that apply to you and provide details next to what you have circled:

Allergies: If yes, to what? _____________________

Arthritis
Anemia
Anxiety
Asthma
Bleeding/Bruising
Blood Pressure Problems: High/Low
Bursitis:______________
Cancer:______________
Cardiac Issues: Heart Attack/Arrythmias
Seizures/Epilepsy
Liver/Gall Bladder
Skin Conditions

Circulation Problems/Numbness
Contact Lenses
Depression
Diabetes
Digestion Problems
Dizziness/Fainting
Endocrine Issues
Fatigue
Fibromyalgia
Headaches/ Migraines
Hepatitis
Smoker
Stress
Stroke

Hernia
Joint Problems
Kidney/Urinary
Lyme Disease
Muscle Strain/Sprain
Neuritis/Neuropathy
Phlebitis/Blood Clots
Pacemaker/Defibrillator
Pins/Plates
Pregnancy
Psychiatric
Respiratory
Ulcers
Varicose Veins
Other_______________

Massage Information

Have you had a professional massage before? Yes No
Explain what type of massage it was: ____

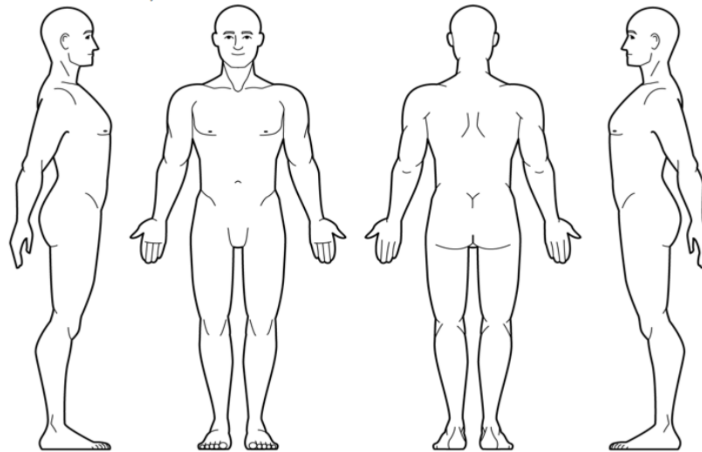
What is your reason for choosing massage and what are your goals for this treatment?

What type of massage do you prefer?
Clinical (deep tissue, sports, orthopedic, trigger point, myofascial release, etc)
Relaxation (Swedish, etc)

What pressure do you prefer?
Light Medium Deep

Do you have any areas of sensitivity that you need a change in pressure (calves, feet, glutes, etc.) or you prefer be avoided (face, scalp, abdomen, etc.)?
Yes No
If yes, please explain:

Please circle any areas of discomfort, pain, or chronic tension:



By signing below, you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature ____________________________________ Date _________________________
Therapist Signature _________________________________ Date _________________________