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New Massage Client History Form/Pain and Discomfort Chart

In order to maximize the effectiveness and safety of massage sessions, please take the time to carefully fill out this questionnaire. This information will be treated confidentially. Use an extra sheet of paper if more space is needed and be sure to reference the question number. Your feedback is appreciated during and at the end of the sessions to help in tailoring the massage session to serve in the best possible way.

Please print clearly.

Name: ____Today's Date:____ /____ /____

Home Address: ______________________________

City, ______________State_____ Zip Code: ________ Date of Birth:____ /____ /____

Cell #:_________________ Home #:______________ Email:____________________

Occupation(s):_______________________________

Referred by:____

Is the massage covered by your insurance? Yes No (If YES Please ask how this will be covered under your plan)

1) Have you had any previous experience with massage? YES [ ] NO [ ]
If yes, please explain whether for stress relief/relaxation or treatment of a specific condition diagnosed by a physician:

____

2) DO YOU HAVE HIGH BLOOD PRESSURE? YES [ ] NO [ ] I'M NOT SURE [ ]

3) DO YOU HAVE ANY COSMETIC BODY IMPLANTS: (Please circle location)
Face Buttocks Breasts

4) FEMALE CLIENTS: Are you pregnant? If so, how far along? __________________

5) Please mark [**X**] for all conditions that apply now. Put a [**P**] for past conditions. Put an [**F**] for family history of illness.

[ ] headaches, migraines
[ ] vision problems, contact lenses
[ ] injuries to face or head
[ ] sinus problems
[ ] dental bridges, braces
[ ] jaw pain, TMJ problems
[ ] asthma or lung conditions
[ ] constipation, diarrhea
[ ] hernia
[ ] birth control, IUD
[ ] abdominal or digestive problems
[ ] chronic pain
[ ] muscle or joint pain
[ ] muscle, bone injuries
[ ] numbness or tingling
[ ] sprains, strains, dislocations
[ ] arthritis, tendonitis
[ ] cancer, tumors
[ ] spinal column disorders
[ ] diabetes
[ ] heart, circulatory problems
[ ] fatigue
[ ] tension, stress
[ ] depression
[ ] sleep difficulties
[ ] allergies, sensitivity
[ ] skin rash, athletes foot, nail fungus
[ ] infectious disease
[ ] blood clots
[ ] varicose veins
[ ] other medical conditions not listed

6) Explain any areas noted above and note if you are currently seeing a doctor for any of the conditions:

____

____

____

7) Current medications you are taking including common nonprescription medications:

____

____

____

8) List all vitamins, herbs, mineral supplements, over the counter medication etc.:

____

____

9) Have you had any surgeries within the last five years? If yes please explain:

____

____

10) Please list all forms and frequency of stress-reduction activities (hobbies, exercise, sports participation, etc.):

____

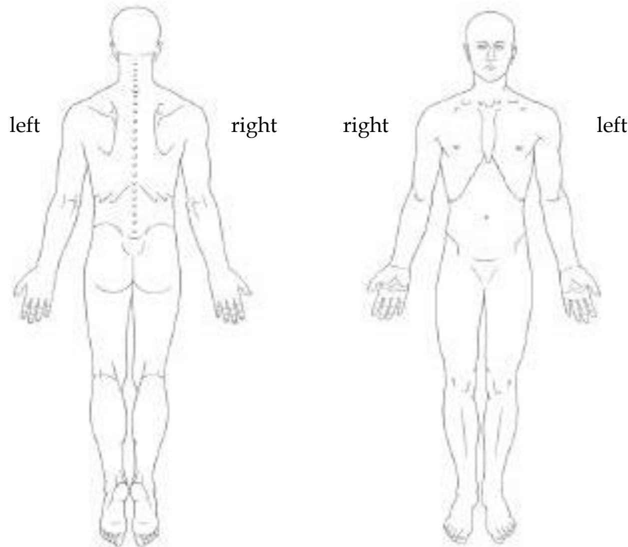
____

11) What is your goal/concern for today's session?

____

PAIN & DISCOMFORT CHART

12) Please indicate the areas where you have pain and describe the level of discomfort using a scale of 1-10 - *(A score of 1 being almost no pain and 10 being the highest level of discomfort).* If your pain seems to refer or "shoot out" to another area of your body please indicate with arrows.



13) For how long have you experienced pain/discomfort in the areas indicated above? ____

14) Describe what you do that causes pain, and what activities make it worse:
____
____
____

I HAVE STATED ALL CONDITIONS THAT I AM AWARE OF AND THAT THIS INFORMATION IS TRUE AND ACCURATE. I WILL INFORM THE MASSAGE THERAPIST OF ANY CHANGES IN MY HEALTH STATUS BEFORE MY NEXT MASSAGE THERAPY SESSION.

I HAVE ALSO READ AND UNDERSTAND THE NEW CLIENT AND ORIENTATION RESPONSIBILITIES.

___________________________________ ____________________
Signature Date